Bill as Introduced

HB 1537 – AS INTRODUCED

2010 SESSION

10-2718
05/10

HOUSE BILL ***1537***

AN ACT allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

SPONSORS: Rep. DiPentima, Rock 16; Rep. Pilliod, Belk 5; Rep. Millham, Belk 5

COMMITTEE: Health, Human Services and Elderly Affairs

ANALYSIS

This bill directs the department of health and human services to amend the Medicaid state plan to permit primary care providers to deliver preventive oral health services to children. The bill requires the providers to be certified before offering such services and makes the program contingent upon future funding.

This bill is a request of the study committee established in 2009, 130 (HB 414).

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 1537 – AS INTRODUCED

10-2718
05/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Ten

AN ACT allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Section; Department of Health and Human Services; Children's Oral Health Initiative. Amend RSA 126-A by inserting after section 4-f the following new section:

126-A:4-g Children's Oral Health Initiative.

I. On or before January 1, 2011, the department of health and human services shall submit a Title XIX Medicaid state plan amendment to the Centers for Medicare and Medicaid Services for the purpose of establishing the children's oral health initiative. The amendment shall authorize primary care providers to deliver preventative oral health services, such as dental screenings and fluoride varnish treatments, to children under the state Medicaid program. Primary care providers who choose to participate in the program shall complete training approved by the department and submit evidence of program completion to the New Hampshire Medical Society, which shall maintain, and make available to the department, a list of certified providers.

II. The commissioner of the department of health and human services shall adopt rules under RSA 541-A relative to administration of the children's oral health initiative, including eligibility criteria, the type and frequency of services covered, reimbursement rates, and provider certification requirements. The department also shall develop a list of approved training programs, which shall include, but may not be limited to, those offered by the American Academy of Pediatrics and the Southern New Hampshire Area Health Education Center.

III. The department shall seek funding for the program as part of the department's budget for the biennium ending June 30, 2013, and each biennium thereafter. Program implementation shall be contingent upon sufficient funding and approval of the state plan amendment required under this section.

2 Effective Date. This act shall take effect 60 days after its passage.

HB 1537 – AS AMENDED BY THE HOUSE

10Feb2010... 0232h

2010 SESSION

10-2718
05/10

HOUSE BILL ***1537***

AN ACT allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

SPONSORS: Rep. DiPentima, Rock 16; Rep. Pilliod, Belk 5; Rep. Millham, Belk 5

COMMITTEE: Health, Human Services and Elderly Affairs

AMENDED ANALYSIS

This bill directs the department of health and human services to seek funding for a children's oral health initiative that would enable primary care providers to deliver preventive oral health services to children between 0 and 3 years of age under Medicaid. The program is contingent upon future funding and approval of a state Medicaid plan amendment.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 1537 – AS AMENDED BY THE HOUSE

10Feb2010... 0232h

10-2718
05/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Ten

AN ACT allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Section; Department of Health and Human Services; Children's Oral Health Initiative. Amend RSA 126-A by inserting after section 4-f the following new section:

126-A:4-g Children's Oral Health Initiative.

I. The department shall seek funding for a Medicaid children's oral health initiative program as part of the department's budget for the biennium ending June 30, 2013, and each biennium thereafter. The program shall provide reimbursement to primary care providers who deliver preventative oral health services, such as dental screenings and fluoride varnish treatments, to children between 0 and 3 years of age enrolled in the state Medicaid program. Primary care providers who choose to participate in the program shall complete training approved by the department and submit evidence of program completion to the department, which shall maintain a list of trained providers. Program implementation, including adoption of rules required by paragraph II, and submission of a Medicaid state plan amendment as required by paragraph III, shall be contingent upon sufficient funding.

II. The commissioner shall adopt rules under RSA 541-A relative to administration of the children's oral health initiative, including eligibility criteria, the type and frequency of services covered, reimbursement rates, and provider training requirements. The department also shall develop a list of approved training programs, which shall include, but may not be limited to, those offered by the American Academy of Pediatrics and the Southern New Hampshire Area Health Education Center. Upon implementation of the program, the department shall provide, upon request, a list of dentists participating in the state Medicaid program to primary care providers in the oral health initiative.

III. The department shall submit a Title XIX Medicaid state plan amendment to the Centers for Medicare and Medicaid Services for the purpose of establishing the children's oral health initiative.

2 Effective Date. This act shall take effect 60 days after its passage.

LBAO
10-2718
Amended 02/17/10

HB 1537 FISCAL NOTE

AN ACT allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

FISCAL IMPACT:

The Department of Health and Human Services states this bill, **as amended by the House (Amendment #2010-0232h)**, will have no fiscal impact in FY 2011. This bill may have an indeterminable impact on state expenditures in FY 2012 and each year thereafter. This bill will have no fiscal impact on state, county, and local revenue or county and local expenditures.

METHODOLOGY:

The Department of Health and Human Services (DHHS) states this bill directs the Department to include a Medicaid benefit expansion for preventative oral health services in its agency budget request for the biennium ending June 30, 2013, and each biennium thereafter. The Department would be required to adopt rules and submit a Title XIX Medicaid state plan amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) if sufficient funding is provided to the Department in the State's FY 2012-2013 operating budget. Implementation of the program would be contingent on sufficient funding and approval of the state plan amendment by CMS. The Department states the proposed bill would have no fiscal impact as it would only require the Department to seek funding for the program and require implementation if sufficient funding is granted.

For informational purposes, the Department states –

- There are approximately 20,000 children, age 0-3 on Medicaid at any given time receiving well child checks.
- At least two annual applications of fluoride varnish are necessary to ensure efficacy. Each service would consist of oral health risk assessment, application of fluoride varnish, provision of anticipatory guidance to caregiver and referral with follow-up to a participating dentist. These services would be reimbursed at $38.00 per encounter.
- Only 75% of children receiving the primary care oral health intervention will ultimately engage with a dentist either because the child already has a dental home or because the family simply does not follow up. Children who are seen by a dentist following the

referral by the primary care physician will receive at a minimum a comprehensive oral evaluation. Evaluations would be reimbursed at $54.50 per visit.

- Claims Payment System modification will be necessary to add this benefit to the menu of reimbursable claims.
- It is anticipated that the application of fluoride varnish and the linkage to a dental home where a children would receive dental services will decrease expenditures for emergency department and operating rooms to treat advanced caries (cavities or tooth decay).

The Department states the maximum exposure of the proposed benefit is approximately $2,337,500 [(20,000 children X $38 per encounter X 2 annual applications = $1,520,000) + (15,000 children X $54.50 = $817,500)], of which 50% or $1,168,750 would be state general funds, assuming all eligible children participate. However, the Department anticipates a slow uptake of this service and thus the high-end cost may not be realized for 3 to 4 years. Thus initial costs of the program will be less and are dependent on the number of providers who avail themselves of the required training and the number of children seen by those providers. In addition, the Department states this maximum exposure estimate is not intended to represent cost avoidances by preventing or arresting dental caries in young children. The Department states in FY 2009 DHHS expended approximately $313,245 in emergency department and operating room (including hospitals and ambulatory surgical centers) for children aged 0-3, 97% of whom were treated due to caries. This figure does not include ancillary charges such as anesthesia, and professional services. For calendar years 2007 and 2008, DHHS expended $740,558 and $904,415 respectively on children aged 0-4, for operating room encounters to treat caries, these figures are inclusive of ancillary costs such as anesthesia, recovery room, pharmacy, and like costs. The Department is unable to determine when such cost avoidances will be realized or how substantial the savings might be. The Department states they would anticipate that application of the federally mandated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program which requires States, among other things, to ensure dental access to Medicaid enrolled children. In order for a dental encounter to count for EPSDT compliance, the encounter must be with a dentist. Accordingly, better linkage of young children with dentists will have an indeterminable benefit for DHHS in relation to its EPSDT mandates as well as potentially improving quality of life for Medicaid enrolled children.

The Office of Legislative Budget Assistant states this bill was a request of the Commission to Study Preventing Dental Disease among New Hampshire's Children which was established pursuant to Chapter 130:2. Laws of 2009. The final report of the Commission issued November 1, 2009 includes the following information –

- The Hawkins Consent Decree (a court-ordered settlement agreement approved in the US District Court in the case of Hawkins v. Commissioner of the Department of Health and Human Services) states that, "Prior to age three oral health screening shall occur in the context of a well-child visit." It further requires that the NH DHHS "shall use its best efforts to provide primary care providers with education and training they need- and to encourage them to take the actions necessary-for the delivery of appropriate oral health screenings to Class Members under the age of three including but not limited to information about prevention of transmission of caries-causing bacteria from parent to child, prevention of early childhood caries, fluoride supplementation, oral hygiene practices tailored to young children, diet and nutrition and when and how to refer Class Members under age three for a dental screening."

- According to the Commission, at the time of the report Northeast Delta Dental had verbally agreed to reimburse trained primary care providers who treat children enrolled in NH Healthy Kids for providing oral risk assessments, anticipatory guidance to the caregiver, fluoride application followed by a referral to a dental home.

- Training programs are available both locally and nationally for primary-care medical providers interested in performing oral health screenings and preventive dental services on high to moderate risk young children. This includes a program by Southern New Hampshire Area Health Education Center and the American Academy of Pediatrics web-based training program.

The Office of Legislative Budget Assistant has prepared this fiscal note in accordance with RSA 14:46, V.

CHAPTER 76
HB 1537 - FINAL VERSION

10Feb2010... 0232h

2010 SESSION

10-2718
05/10

HOUSE BILL ***1537***

AN ACT allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

SPONSORS: Rep. DiPentima, Rock 16; Rep. Pilliod, Belk 5; Rep. Millham, Belk 5

COMMITTEE: Health, Human Services and Elderly Affairs

AMENDED ANALYSIS

This bill directs the department of health and human services to seek funding for a children's oral health initiative that would enable primary care providers to deliver preventive oral health services to children between 0 and 3 years of age under Medicaid. The program is contingent upon future funding and approval of a state Medicaid plan amendment.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

CHAPTER 76
HB 1537 – FINAL VERSION

10Feb2010... 0232h

10-2718
05/10

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Ten

AN ACT allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

Be it Enacted by the Senate and House of Representatives in General Court convened:

76:1 New Section; Department of Health and Human Services; Children's Oral Health Initiative. Amend RSA 126-A by inserting after section 4-f the following new section:

126-A:4-g Children's Oral Health Initiative.

I. The department shall seek funding for a Medicaid children's oral health initiative program as part of the department's budget for the biennium ending June 30, 2013, and each biennium thereafter. The program shall provide reimbursement to primary care providers who deliver preventative oral health services, such as dental screenings and fluoride varnish treatments, to children between 0 and 3 years of age enrolled in the state Medicaid program. Primary care providers who choose to participate in the program shall complete training approved by the department and submit evidence of program completion to the department, which shall maintain a list of trained providers. Program implementation, including adoption of rules required by paragraph II, and submission of a Medicaid state plan amendment as required by paragraph III, shall be contingent upon sufficient funding.

II. The commissioner shall adopt rules under RSA 541-A relative to administration of the children's oral health initiative, including eligibility criteria, the type and frequency of services covered, reimbursement rates, and provider training requirements. The department also shall develop a list of approved training programs, which shall include, but may not be limited to, those offered by the American Academy of Pediatrics and the Southern New Hampshire Area Health Education Center. Upon implementation of the program, the department shall provide, upon request, a list of dentists participating in the state Medicaid program to primary care providers in the oral health initiative.

III. The department shall submit a Title XIX Medicaid state plan amendment to the Centers for Medicare and Medicaid Services for the purpose of establishing the children's oral health initiative.

76:2 Effective Date. This act shall take effect 60 days after its passage.

Approved: May 19, 2010

Effective Date: July 18, 2010

Committee Minutes

Printed: 03/31/2010 at 9:02 am

SENATE CALENDAR NOTICE
HEALTH AND HUMAN SERVICES

Senator Kathleen Sgambati Chairman
Senator Peggy Gilmour V Chairman
Senator Molly Kelly
Senator John Gallus
Senator Michael Downing

For Use by Senate Clerk's Office ONLY
☐ Bill Status
☐ Docket
☐ Calendar
Proof: ☐ Calendar ☐ Bill Status

Date: March 31, 2010

HEARINGS

Tuesday **4/6/2010**

(Name of Committee)	(Place)	(Time)
HEALTH AND HUMAN SERVICES	SH 103	8:30 AM

EXECUTIVE SESSION MAY FOLLOW

8:30 AM	HB1226	relative to caregiver support services for the elderly.
8:45 AM	HB1537	(New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.
9:00 AM	HB1566-FN	requiring financial institutions to disclose certain information regarding recipients of medical assistance for the aged, blind, and disabled through an electronic asset verification system.
9:15 AM	HB1572-FN	relative to the certification of integrated residential communities.

Sponsors:

HB1226
Rep. Alida Millham

HB1537
Rep. Rich DiPentima, Rep. James Pilliod, Rep. Alida Millham

HB1566-FN
Rep. John Cebrowski, Rep. Thomas Donovan, Rep. Charles McMahon, Rep. Chris Nevins

HB1572-FN
Rep. Thomas Donovan, Rep. Catriona Beck

Deborah Chroniak 271-3096

Sen. Kathleen Sgambati
Chairman

Health and Human Services Committee

Hearing Report

TO: Members of the Senate

FROM: Heidi Mitchell, *Legislative Aide*

RE: Hearing report on **HB 1537-FN** – *AN ACT (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.*

HEARING DATE: April 6, 2010

MEMBERS OF THE COMMITTEE PRESENT: Sen. Sgambati; Sen. Gilmour; Sen. Downing; Sen. Gallus.

MEMBERS OF THE COMMITTEE ABSENT: Sen. Kelly.

Sponsors: Rep. DiPentima, Rock 16; Rep. Pilliod, Belk 5; Rep. Millham, Belk 5.

What the bill does: This bill directs the department of health and human services to seek funding for a children's oral health initiative that would enable primary care providers to deliver preventive oral health services to children between 0 and 3 years of age under Medicaid. The program is contingent upon future funding and approval of a state Medicaid plan amendment.

Who supports the bill: Sen. Gilmour, Dist. 12; Rep. Cebrowski, Hills. 18; Rep. Batula, Hills. 19; Rep. Frank Kotowski, Merr. 9; Rep. Skinder, Sull. 1; Rep. Millham, Belk. 5; Rep. Gile, Merr. 10; Rep. Emerton, Hills. 7; Rep. DiPentima, Rock. 16; Tim Soucy, City of Manchester Health Department; Dr. Suzanne Boulter; Catrina Watson, New Hampshire Medical Society; Angela Boyle, New Hampshire Oral Health Coalition; Marie Mulroy, Breathe NH; Kathy Manwile, RN, MS, MPH; James J. Williams, New Hampshire Dental Society; Lisa Kaplan Howe, New Hampshire Voices for Health; Hope Saltmarsh, RSH, MEd; Kristina Diamond, New Hampshire Public Health Association; Denis Brewitt, Council for Children & Adolescents with Chronic Health Condiditions; Suzan Paschell, New Hampshire Dental Hygienists Association; Gail Garceau, New Hampshire Healthy Kids.

Who opposes the bill: No one.

Others who testified: Lisabritt Solsky, Department of Health and Human Services.

Summary of testimony received: Rep. DiPentima introduced the bill to the committee.

Rep. DiPentima

- Introduced the bill, stated that this legislation was recommended by a Study Commission established last year as a result of the passing of HB 414. The Commission, which Rep. DiPentima chairs, was charged to study preventing dental disease among NH children.
- This bill directs DHHS to amend the State Medicaid Plan to allow reimbursement to appropriately trained primary medical care providers who perform oral screening and preventive services on Medicaid children age 0-3 years old. This policy is currently in effect in 36 states including every other New England state. There was no opposition to the bill in the House Health and Human Services & Elderly Affairs Committee. Supporters include Dr. Susan Lynch.
- Dental caries (a destructive tooth decay process) are the most prevalent chronic infectious disease in children; however it is almost 100% preventable. NH Head Start programs show that approximately 40% of children have evidence of treated and or/untreated dental decay. Considering the impact on children's overall health, education, pain and suffering and the great financial burden it places on our society, we recognize this problem to be a major public health concern.
- Between 2007-2008, 983 Medicaid eligible children required treatment in hospital operating rooms under general anesthesia for removal of most or all of their teeth due to untreatable decay, 519 were children age 0-4. These treatments cost the State General Fund over $1.5 million. In 2009, DHHS expended $323,245 in emergency room department fees and operating rooms for children age 0-3. This figure does not include the costs of professional and ancillary services.
- Evidence based data shows that high to moderate risk children age 0-3 benefit most from early intervention and prevention such as fluoride varnish but that few actually receive the procedure. This is because not all children age 0-3 have access to a dentist – but most children these ages see their PCP between 9-15 times in their first few years of life. This bill would allow PCP's to be trained in order to administer the fluoride varnish on children age 0-3.
- Hawkins v. Commissioner DHHS – The State was successfully sued in Federal Court by a group of Medicaid clients regarding lack of access to dental care in 1999.

Tim Soucy, Public Health Director, City of Manchester Health Department

- In support of the bill, Mr. Soucy stated that in a recent report issued by the National Maternal & Child Oral Health Resource Center, dental caries continue to be the most common childhood illness in the US, with nearly half of children ages 2-19 having dental caries in their permanent teeth. Oral health status is a serious issue in Manchester, impacting physical, social, economic and psychological health. Allowing PCP's to administer the fluoride varnish will create a long-term return on investment in future procedures these children will not need as they age.

Dr. Suzanne Boulter

- In support of the bill, Dr. Boulter stated that the National Academy for State Health Policy in 2008/2009 documented that using primary care providers to promote preventative oral hygiene and good nutritional habits, refer patients to a dental home by age 1, and apply fluoride varnish as a proven caries reducing

strategy has allowed states to have an opportunity to better serve young children and work toward a goal of reducing state expenditures on costly restorative care.

- NC, which has been providing training and reimbursement the longest, has seen a 38% decrease in the need for restorative dental care at age 3, while children on Medicaid had a significant increase in dental visits.
- In NH, there are 757 practicing dentists but only 24 Pediatric Dentists, none of whom practice in the northern half of the state (Dental Services and workforce in NH 2010, NH Center for Public Policy). There are about 230 practicing pediatricians plus family physicians and nurse practitioners who can be trained to deliver preventive screening oral health services during well child visits.
- Dr. Boulter submitted testimony given by Dr. Susan Lynch to the House Health and Human Services & Elderly Affairs Committee in support of the bill.
- In response to questions from the committee, Dr. Boulter stated that the American Academy of Pediatrics provides a free, one-hour online training for pediatricians wishing to be trained. She noted that there would need to be incentives from the state in regards to reimbursement as doctors generally receive $0.50 for every $1 spent from Medicaid.

Angela Boyle, RDH, BS, Director, New Hampshire Oral Health Coalition

- In support of the bill, Ms. Boyle stated that according to the 2007 CMS EPSDT Participation Report, 900 out of 17,000 children ages 0-2 enrolled in Medicaid received preventative dental services. DHHS is obligated to ensure that dental care takes place at as early an age as necessary according to 42C.F.R §441.56 (c).
- Southern New Hampshire University already provides information to providers along with the New Hampshire Oral Health Coalition and Delta Dental they will be holding an educational training this spring.

Lisabritt Solsky, Deputy Medicaid Director, Department of Health and Human Services

- Neutral on the bill, Ms. Solsky stated that DHHS sees value in this legislation and recognizes the possible linkage between young dental hygiene and health problems later on in life. However, she stated that with the 2010/2011 budget still being slashed it is more difficult than ever to find money for new programs. She said that if the bill is passed, they will include it in their budget.
- In response to questions from the committee, Ms. Solsky stated that children age 4-5+ are more engaged with dental care while age 0-3 have more barriers in receiving care from a dentist. She also stated that the program would likely see a slow ramp-up which means the department will have to spend money before seeing the offset in care not needed later in these children's' lives. She estimated it would take 3-5 years to see the change, but stated that the value isn't necessarily just in money saved but in the quality of life for these children and help establish better habits throughout their lifetime so it's hard to quantify. Ms. Solsky also noted that it would take a while to compute what added complications with emergency room oral procedures currently cost the State.

Rep. Skinder

- In support of the bill, Rep. Skinder has worked for many years as an Emergency Room nurse at Valley Regional Hospital. She stated that she saw better dental health while working in Sierra Leone than in the Upper Valley. Rep. Skinder

emphasized the importance of starting children off on the right foot when it comes to dental hygiene. As a nurse she believes that it would be easy for nurses and PCP's to learn how to administer the fluoride varnish.

Gail Garceau, President, New Hampshire Healthy Kids

- NH Healthy Kids supports the concept of HB 1537 and requests that it include children covered in their Silver program as it would assist in expanding access to necessary dental services.

Denise Brewitt, Executive Director, Council for Children and Adolescents with Chronic Health Conditions

- In support of the bill, stated that children with chronic health conditions have a higher rate of dental illness because of access to proper care and asked that the committee keep in mind the population of children who are at an even higher risk.

Funding: See fiscal note. By his own calculations, Rep. DiPentima believes the estimate of cost will be far less than the fiscal note shows, and Rep. Kurk (House Finance Committee) agreed that Rep. DiPentima's calculations are more realistic than the fiscal note. Rep. DiPentima believes the state will have a total net savings of $64,738-$85,964 and a total savings after costs of program will run between -$844-$7,773 for FY 2012-2013.

Future Action: The Committee took the bill under advisement.

hmm
[file: HB 1537-FN report]
Date: April 8, 2010

Date: April 6, 2010
Time: 8:46 A.M.
Room: SH RM 103

The Senate Committee on Health and Human Services held a hearing on the following:

HB 1537	(New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

Members of Committee present:	Senator Sgambati Senator Gilmour Senator Kelly Senator Gallus Senator Downing

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The Chair, Senator Kathleen G. Sgambati, opened the hearing on HB 1537 and invited the prime sponsor, Representative Rich DiPentima, to introduce the legislation.

Senator Kathleen G. Sgambati, D. 4: Good morning.

Representative Rich DiPentima: Good morning, Madam Chair, members of the Health and Human Services Committee. For the record, I'm Representative Rich DiPentima, representing Rockingham District 16, which is Portsmouth and Newington. I am a member of the Health and Human Services Elderly Committee and prime sponsor of HB 1537.

HB 1537 is legislation that was recommended by a study commission of which I was chair that was the outgrowth of HB 414 from last session. The bill directs the Department of Health and Human Services to amend the State Medicaid Plan to allow reimbursement to appropriately trained primary medical care providers who perform oral screenings and preventive services on Medicaid children age zero to three years old. And, just for the record, since I've heard some interesting comments about this age of zero to three, we have that age starting at zero only because that includes zero to up to one year of age. And, we know that children as early as six to nine months have erupting denture, erupting dental and have a number of teeth by the time they reach their first birthday, so they do, would benefit from this

program. This policy is currently in effect in 36 states, including every other New England state. And, this policy was very well received in the Health and Human Services and Elderly Affairs Committee with a very active public hearing, with no opposition, and, in fact, Dr. Susan Lynch was one of the individuals who came and testified, and our Committee voted 18 to 0 as ought to pass.

The commission that I was chair that was to study preventing dental disease among New Hampshire children, this was one of the issues that was primary, that came out during our hearings and testimony from over 18 individuals, both from New Hampshire and around the country, talking about the benefits of allowing primary care providers to provide the service to particularly high to moderate risk children who are Medicaid enrolled.

I'm here to talk mainly about the policy issues of this bill, and I assume that's what you like, but I am prepared if you'd like, to discuss the financial part of it. I have an analysis that I did that, if you have questions about that, I'd be happy to talk about that. But, I'm going to focus on the policy side.

Dental cavities are the most prevalent chronic infectious disease in children; it is an infectious disease; however, it is almost 100% preventable. Surveys of children in New Hampshire Head Start programs and third grade show that approximately 40% of these children have evidence of treated or untreated dental decay. In the past, dental disease in children was considered a minor problem; however, considering the impact on children's overall health, education, pain and suffering, and the great financial burden it places on our society, we now recognize this problem to be a major public health concern.

An estimated 51 million school hours are lost each year in America because of dental-related issues and an average of 3.1 days of school are lost per 100 students. In New Hampshire, in the years 2007 and 2008 combined, 983 Medicaid eligible children required treatment in hospital operating rooms under general anesthesia for the removal of most or all of their teeth. Of these, 519 were children age zero to 4 years old. The treatment cost the State General Fund over $1.5 million, not to mention the great pain and suffering these children endured and that the treatment did not even resolve the underlying condition. In calendar year 2008, 312 children enrolled in Medicaid were seen in emergency rooms for dental conditions. In 2009, DHHS expended over $313,000 in emergency department operating room costs for children zero to three years of age. This figure does not include the cost of professional and ancillary services, which, when included, would at least double this cost.

So, why is it such a problem for Medicaid children age zero to three? Evidence-based data showed that high to moderate risk children aged zero to three benefit the most from early intervention and prevention services, such as fluoride varnish, but very few actually receive this procedure. Why is this the case? There are currently 926 active dentists in New Hampshire; 787 who are general dentists. Of the total dentists, 625 enrolled in Medicaid, but only 397 actually billed Medicaid in 2009. Furthermore, of those general dentists who do see Medicaid children, very few will see children age zero to three, obviously because they're not trained or very comfortable dealing with children at that age group. The reason for this very...is that they're not trained, as I mentioned. Most importantly, there are only 24 pediatric dentists in New Hampshire, which severely limits the number of young children who see a dentist. In New Hampshire, of the approximately 21,000 children age zero to three on Medicaid, only 2,800 actually have seen a dentist.

On the other hand, almost every Medicaid child age zero to three sees a primary care provider between nine and fifteen times in their first years of life. This represents currently a great missed opportunity to prevent dental disease in these children. Almost every PCP accepts Medicaid, and they are quite comfortable in treating young children. With the appropriate minimal training that the PCP would be required to obtain at their own expense, many more children would be able to receive the effective preventive benefits of fluoride varnish.

There's another issue that I'll just briefly mention, and it's here and you can read about it, it's the Hawkins lawsuit that the state is currently dealing with. And, the issue related to the motion to hold the state in contempt for not complying with the Consent Decree that was agreed to by the state and the plaintiffs in 2004. That motion is still pending. But, one of the items of interest here is that in the Memorandum of Law that was submitted by the plaintiffs with the Motion for holding the state in contempt, was that this program that we're talking about today would be one of those issues that would have helped resolve this lawsuit, and bring the state closer to compliance with the Consent Decree.

Lastly, I realize the Committee's primary concern with policy issues, as I mentioned; however, especially in these difficult times, anything that looks like it will increase the state's financial burden is received with great skepticism, to say the least. Please allow me to briefly present my estimate of the potential costs/benefits that would result from adoption of HB 1537. I know you have a fiscal note that's attached with this bill, and that fiscal note, which I think for obvious reasons is done to present the absolute worst case

scenario that the state would face, which, to me is unrealistic considering the fact that of the other states that have done this, none, none have actually approached attaining 100% participation of all these Medicaid eligible with the children. It's more like 10% of children will begin in the program and then gradually increase over a number of years. Maine, who has been doing this program for a number of years, only has about 1,500 children enrolled, currently. And, North Carolina who's been doing this for many, many years probably is up around 50 or 60%. So, the cost analysis that you see with the fiscal note, I consider unrealistic considering the experience of all these other states.

In my analysis, which I'd be happy to share with you if you'd like, shows that this basically, in the first year, this would be a budget neutral bill, and then in the future years we would start to see cost savings based on very, very conservative estimates of the number of children who would be prevented from having to go to the operating room for services, a 5% reduction in operating room services, and some reduction in restoration cost for children for filling of cavities.

Senator Kathleen G. Sgambati, D. 4: Thank you.

Representative DiPentima: So, with that, I'd be happy to answer any questions you may have on HB 1537. And, if you'd like my cost analysis, I'd share that with you.

Senator Kathleen G. Sgambati, D. 4: Yes, it would be helpful to submit that and we'll review it at a later time. I want to make sure everyone get's a chance to speak.

Representative DiPentima: I'm sorry, I can't hear you.

Senator Kathleen G. Sgambati, D. 4: If you could just submit that and then we'll continue with the hearing so that everyone can speak. Questions from the Committee? If not, thank you very much.

Representative DiPentima: Thank you.

Please see Attachment #1 – Prepared written testimony of Representative Rich DiPentima.

Please see Attachment #2 – Prepared Estimated Cost Analysis for the Implementation of HB 1537.

Senator Kathleen G. Sgambati, D. 4: I'm going to ask, since we have several speakers, to ask people to try to keep their testimony brief. And, I'll call next on Tim Soucy. While Tim is coming up, I also have Representative Cebrowski, and Representative Batula, in favor, but not speaking. Good morning.

Tim Soucy: Good morning, Madam Chair, members of the Committee. My name is Tim Soucy. I'm the Public Health Director for the City of Manchester and I'm here today to urge your support of HB 1537.

According to a recent report issued by the National Maternal and Child Oral Health Resource Center, dental carries continue to be the most common childhood illness in the United States. Nearly half of children between the ages of two and nineteen have dental carries in their permanent teeth. Oral health status continues to be a serious problem in the City of Manchester, impacting physical, social, economic and psychological health. Poor oral health affects speech, nutrition, self-esteem and a child's ability to learn, particularly those in lower socioeconomic status.

Health professionals are in a unique position to improve the oral health of Medicaid enrolled children in our state. By completing an oral health risk assessment and applying fluoride varnish during well child visits, then following up with a referral to a dental home, primary care providers can have a positive impact on the overall health of children they serve by ensuring that preventative measures are undertaken beginning early in life.

While I understand the fiscal realities of expanding Medicaid benefits, I believe this bill will provide a long-term return on investment, not only financially, but most importantly on improving the oral health, overall health and qualify of life of our Medicaid enrolled children.

And, I want to thank you for your time this morning.

Senator Kathleen G. Sgambati, D. 4: Thank you very much. Questions?

Mr. Soucy: Thank you.

Please see Attachment #3 – Prepared written testimony of Timothy Soucy.

Senator Kathleen G. Sgambati, D. 4: If not, thank you.

Dr. Boulter? And, I also have Catrina Watson signed up in favor of the bill, but not speaking.

Good morning.

Dr. Suzanne Boulter: Thank you very much, Senator. And, in addition to some of the comments that have already been made, you're probably aware that the National Academy for State Health Policy has come out with two policy briefs, one in '08 and one in '09, that really promote the funding for preventive oral health services because that, in the long run, reduces state expenditures. I know that point has already been made, but it's hard to measure money that you're not going to spend in the operating room, and that's always tricky. But, if we can even save one or two children from these massive operating room procedures, we can probably fund this program 10 times.

Also, data from North Carolina, which has had primary care involvement for many years now, shows an almost 40% reduction in the need for restorative services. So, the savings will be real. And at the same time, there was a marked increase in the number of Medicaid children in North Carolina that did see a dentist. So, it's win-win; fewer in the operating room and more that are actually seeing a dentist.

And, just to make the point again, almost every child in New Hampshire who's on Medicaid and who's poor does have access to a medical home. And, medical offices have opened their doors to Medicaid clients because it's the right thing to do for children. And, we see these children up to 12 times just for well-child care in the first three years of life. So, we would have ample opportunity to take on oral health prevention during those visits.

Now, you might ask, and some have asked, why aren't you doing it now? And, here's the reason. None of us were trained in oral health prevention. We have to get trained, we have to have more supplies, we have to add time for each office visit, and all of that comes at a cost. In other words, if each visit takes longer, you can see fewer patients per day. So, I think it's only fair to give primary care physicians an extra reimbursement to incentivize them to perform the oral health preventive services for children in the first three years of life, and to refer them to a dental home. Ideally we'd have dental homes for all of these children, and that is our wish, but as you've already heard, with only 24 pediatric dentists in New Hampshire, none of whom practice in the northern half of the state, that is a pipe dream, it's not going to happen.

So, I definitely support passage of bill 1537. And, with your permission, I have the testimony from Dr. Susan Lynch who was not able to be here this morning because of a conflict. She did testify at the House hearing, and I don't know if you'd like me go over some of the points?

Senator Kathleen G. Sgambati, D. 4: I think if we can...we'll just give it to members and have them read it...

Dr. Boulter: Okay.

Senator Kathleen G. Sgambati, D. 4: ...so that we don't...

Dr. Boulter: That's great. Thank you.

Senator Kathleen G. Sgambati, D. 4: ...lose it.

Dr. Boulter: Yes. Okay.

Senator Kathleen G. Sgambati, D. 4: Questions? Yes, Senator Gilmour.

Senator Peggy Gilmour, D. 12: Thank you. Thank you, Dr. Boulter, for your testimony. You're...to do this, the primary care physician...the pediatrician, will need to be trained at his or her own expense.

Dr. Boulter: Yes.

Senator Peggy Gilmour, D. 12: And, then will take on an additional Medicaid procedure at probably reimbursement below cost.

Dr. Boulter: Reimbursement, what?

Senator Peggy Gilmour, D. 12: That typically your Medicaid...what you get doesn't equal your cost.

Dr. Boulter: That's right.

Senator Peggy Gilmour, D. 12: So, in your estimation as a pediatrician in the real world, how successful will we be in getting pediatricians to go forward at their own expense to get the training...

Dr. Boulter: Hm-hmm.

Senator Peggy Gilmour, D. 12: ...to accept this new level of care?

Dr. Boulter: It's a good question. And, I've been part of a national group with the American Academy of Pediatrics that's developed free on-line training that is available right now to any primary care doctor; it's an hour on-line. There's also an extended module of 13 hours if people get really interested in oral health, but even just after going on the web, the AAP website, and taking this one-hour training, that is enough for pediatricians to then institute oral health services in their practices. In my opinion, what would be ideal is to have, have someone that could actually demonstrate, like a dental hygienist, or another pediatrician that's familiar with how to do, looking in the teeth. It sounds simple, but there are some tricks involved. And, I think myself and other people would be happy to share our experience with the pediatricians around the state.

So, I do think that they will be interested, but if there's zero extra reimbursement, and it's just going to take them more time, and they're already being reimbursed fifty cents on the dollar, I'm just not sure that it's going to happen.

Senator Kathleen G. Sgambati, D. 4: Thank you.

Senator Peggy Gilmour, D. 12: Thank you.

Senator Kathleen G. Sgambati, D. 4: I have a question.

Dr. Boulter: Yes.

Senator Kathleen G. Sgambati, D. 4: Are dentists...I mean, are pediatricians doing this now for private paid insured? I mean, this specifies Medicaid.

Dr. Boulter: Right. That's a good question. That will be the next area of activity. In Massachusetts there's a bill that's going to require all of the private insurers in Massachusetts to give reimbursement for oral health services for children. Of course, Massachusetts is always requiring insurers to cover many things. And, I think they're the first state that does that.

In Washington State, Delta Dental pays primary care providers directly for providing these services. And, in this state, Delta Dental has agreed that they will fund the SCHIP or New Hampshire Healthy Kids Medicaid Silver, not Medicaid, excuse me, the Healthy Kids Silver Program. They are willing to directly pay primary care providers for providing these services. That has not happened yet.

Senator Kathleen G. Sgambati, D. 4: Thank you. Thank you very much.

Dr. Boulter: Thanks.

Please see Attachment #4 – Written submission by Dr. Suzanne Boulter.

Please see Attachment #5 – Prepared written testimony of Dr. Susan Lynch, submitted by Dr. Suzanne Boulter.

Senator Kathleen G. Sgambati, D. 4: Angela Boyle? And, I also have Marie Mulroy from Breathe New Hampshire, in favor, but not speaking, and Kathy Mandeville, in favor, and James Williamson of the Dental Society, Lisa Kaplan Howe, and Hope Saltmarsh, all in favor, but not speaking, and Representative Kotowski.

Angela Boyle: Good morning.

Senator Kathleen G. Sgambati, D. 4: Good morning.

Ms. Boyle: My name's Angela Boyle, I'm the Director of the New Hampshire Oral Health Coalition. I'm also a 20-year registered and licensed dental hygienist here in the State of New Hampshire. Many of the points that I have in my testimony have already been mentioned, so I'll just touch on a couple things.

Integrating oral health for primary care for young children has been key in preventing dental disease in other states. The New Hampshire Oral Health Coalition believes that this policy initiative really does make sense. This approach doesn't, this approach expands the type of providers who can access, who provide access to preventive services, but it doesn't expand the number of eligible recipients or provide new services.

Also, I'd like to point out that each state is federally mandated to provide any child enrolled in Medicaid with the early periodic screening, diagnosis, and treatment services, and the state is obligated to ensure that the dental care takes place as an early age as necessary, according to the federal code, and I put that in here.

Also, we believe that this really does create a system level improvement and that is outlined in the New Hampshire Oral Health Plan, so I have a copy of that for you and I've marked the page that indicates that.

Senator Kathleen G. Sgambati, D. 4: Thank you.

Ms. Boyle: As Dr. Boulter mentioned, there is training available for primary care physicians, both locally and nationally. The Southern New Hampshire Area Health Education Center has already established an accredited training program that they go out into primary care offices and train any OB/GYN, pediatricians, family practitioners on exactly this information. And then, also, in June, the New Hampshire Health Coalition, along with the New Hampshire Technical Institute and Delta Dental are putting on a big conference that will help train providers, and it will be hands-on, so that's going to be available in a couple of months.

So, with that, the New Hampshire Oral Health Coalition strongly supports this bill. We were part of the study commission that spent hours over the summer looking at how to prevent this, and we really feel that this is a great way to keep kids healthy.

Senator Kathleen G. Sgambati, D. 4: Great. Thank you very much.

Ms. Boyle: So, with that...And, Senator, I also have some written testimony from New Hampshire Voices, Lisa Kaplan that signed in.

Senator Kathleen G. Sgambati, D. 4: Okay.

Ms. Boyle: And, then I also have some written testimony from Wolfeboro Pediatrics, Dr. Matos, in favor of this bill, as well.

Senator Kathleen G. Sgambati, D. 4: Okay. Thank you.

Ms. Boyle: So, I'll give you that.

Please see Attachment #6 – Prepared written testimony of Angela Boyle.

Please see Attachment #7 – Annual EPSDT Participation Report for FY 2007.

Please see Attachment #8 – New Hampshire Oral Health Plan: A Framework for Action, July 2003

Please see Attachment #9 – Prepared written testimony from New Hampshire Voices for Health, Lisa Kaplan Howe, submitted by Angela Boyle.

Please see Attachment #10 – Prepared written testimony of Dr. Michael Matos, Wolfeboro Pediatrics, submitted by Angela Boyle.

Senator Kathleen G. Sgambati, D. 4: We will make sure that the Committee members see them. Thank you very much.

Lisabritt Solsky?

Lisabritt Solsky: Good morning, Madam Chairman...

Senator Kathleen G. Sgambati, D. 4: Good morning.

Ms. Solsky: ...members of the Committee. For the record, I'm Lisabritt Solsky. I'm the Deputy Medicaid Director. We understand the responsibilities for the Department under this bill to be three-fold. First, to include a proposal to fund this program in our agency budget for '12 and '13; second, assuming it's funded, to prepare administrative rules and a state plan amendment to include this service for reimbursement under the Medicaid State Plan, and we can fulfill these responsibilities should the bill pass.

As a matter of policy, the Department does see value in engaging primary care providers in uniting all Medicaid children with a dental home, and we would hope that that would be part of the rollout of this initiative. And, we do recognize that there is the possible linkage to our responsibilities under early periodic screening diagnosis and treatment of young children which, as Angela mentioned, is a federal requirement under Medicaid to unite all children with the services reasonably necessary to fulfill their medical needs.

As was stated earlier, we know that in calendar 2007 and calendar 2008, the Medicaid program paid approximately $1.6 million in total funds in claims to dentists to provide dental care in an outpatient or ambulatory surgical setting. And, we know that about 99% of the dental related operating room costs were for children zero to three years of age. And, we understand that many other states have implemented this initiative and have reported positive results, including cost avoidance for invasive restorative care and/or invasive surgical care. We do expect that, as with any new initiative, there will be slow ramp up.

As was mentioned, our fiscal note assumed a worst case scenario; we do believe that that is our responsibility, but we do identify it as the worst case scenario. And, as part of that, we did assume 100% penetration of the zero to

dac

three cohorts, understanding though that, in the first few years, we would not come close to that 100% penetration.

We do find ourselves though in a very difficult situation going into the '12 and '13 budget cycle. We're still slashing the '10-'11 budget, and that will obviously make the situation for '12 and '13 the more dire. Having said that, if this bill passes, we will include this initiative in our agency budget proposal, and it will be up to the Legislature in '12 to decide, or excuse me, in '11 to decide whether this is a meritorious program and the funding is available. I'm happy to take any questions.

Senator Kathleen G. Sgambati, D. 4: Thank you. I do have a question. Does Medicaid...this is zero to three, what happens to four, five year olds?

Ms. Solsky: The evidence suggests that children ages four and above are far more likely to be engaged with a dental home and receiving preventive care and restorative care should they need it. The zero to three cohorts, particularly of low and extremely low income households, have greater barriers to accessing oral health care in a dentist's office. So, the primary focus has been children aged zero to three.

Senator Kathleen G. Sgambati, D. 4: Thank you. Other questions? Senator Gilmour.

Senator Peggy Gilmour, D. 12: Thank you. Thanks, Lisabritt. This is really just a question; I'm asking you for your gut response. So, if we spent, in 2007 and 2008, $1.6 million, and most of those were in very young children in the OR, and you've looked at Representative DiPentima's kind of gut analysis. In your mind, is it realistic? I mean, when we talk about cost avoidance.

Ms. Solsky: Again, with a slow ramp up, it will be slower to see these cost avoidance. I think it is highly likely, and I believe that our fiscal note reflects it, I think that it's highly likely that there would be cost avoidance realized in, maybe starting in year three, because again, in the ramp up we're going to roll out...we'll spend money before we start saving money. So, maybe in years three through five, we might start seeing some of that cost avoidance. It is a rather difficult thing to quantify in real time. And, I think you've heard ample testimony that the value of the initiative is not necessarily in dollars saved, but in quality of life improved for young children who don't have to endure the pain and suffering, possible embarrassment, and barriers at school that they endure if they're suffering from a lot of pain and a lot of decay. Certainly, we would hope that unification with good oral health education that is also contemplated as part of this service, would help to establish better habits through the lifetime, which, again, we would hope

would yield greater cost avoidance, but again, which is very difficult to quantify.

Senator Peggy Gilmour, D. 12: Follow up?

Senator Kathleen G. Sgambati, D. 4: Quickly.

Senator Peggy Gilmour, D. 12: Okay. In that $1.6 million, is that pure payment for a coded service, or do you ever figure out if there are complication rates? I mean, these are kids who are going to the hospital under anesthesia.
Ms. Solsky: It would take more analysis.

Senator Peggy Gilmour, D. 12: Okay.

Ms. Solsky: ...for me to determine in which of those we had to pay an additional rate due to unforeseen complications. There is a modifier that goes on the code where we can see if an enhanced reimbursement was provided due to complication, but that is a more sophisticated level of analysis.

Senator Peggy Gilmour, D. 12: Thank you.

Senator Kathleen G. Sgambati, D. 4: Thank you.

Ms. Solsky: Thank you.

Senator Kathleen G. Sgambati, D. 4: Representative Carla Skinder? Sorry, I didn't see it before.

Representative Carla Skinder: Thank you. That's all right. Thank you very much.

Senator Kathleen G. Sgambati, D. 4: Just going ahead on the list.

Representative Skinder: Good morning, Madam Chair, honorable members of the Senate Health and Human Services. My name is Carla Skinder. I represent Sullivan 1, which is Cornish, Grantham, and Plainfield.

I am a registered nurse and I have a master's in public health. I worked as a emergency room nurse for many, many years, and when I first moved to... California; New Hampshire, I started working for Valley Regional Hospital in Claremont. I have had the opportunity to travel all over the world. I worked in the poorest nation in the world, which is Seria Leone, and their smiles

were much better than Claremont and Newport. I was really discouraged to see that.

In our hospital, as a manager, I would have to look at the yearly budgets to know almost 1,000 people came through our emergency room just for dental needs; pain, primarily. This is so important to get children on the right, right feet.

My neighbor's a pediatrician; most of his clients are Medicaid. This would help to prevent him from getting up at two in the morning for a child that's in pain, crying with dental pain, whether it be zero to three, three to five; but, we also have to realize if we start the process now, we get people engaging in better oral health, that the zero to three, the five to seven, to 100 years of age...And, I have...I run an adult medical day care now with mostly Medicaid adults that have terrible dentition. This could perhaps prevent all of that also, which costs us a great amount of money as people grow.

I'm in Rotary. We provide thousands of dollars a year to get dental care to children. We are now realizing we need to put it in the primary setting as opposed to taking one child and doing his whole mouth.

So, this is really a great move. As a nurse, we learn many procedures through our lifetime of nursing; doctors do, too. This is a very simple procedure for a pediatrician to learn. Dental hygienists do it; nurse practitioners would be able to it, perhaps down the road, but this is something that would greatly save a lot of money and a lot of pain for many people. And, I hope that you'll consider this bill. Thank you very much.

Senator Kathleen G. Sgambati, D. 4: Thank you. Questions? All set?

Gail Garceau?

Gail Garceau: Good morning. My name is Gail Garceau and I'm the President of New Hampshire Healthy Kids. And, much of what I was going to say this morning has already been said.

So, I will be very brief and say that New Hampshire Healthy Kids supports the concept of HB 1537 to permit primary care providers to deliver preventive oral health services to children zero to three. And, on behalf of New Hampshire Healthy Kids Silver population, New Hampshire Healthy Kids would like to request that those covered in our Silver Program be included in any action on this bill; that it would assist in expanding access to necessary dental services. Thank you very much.

Please see Attachment #11 – Prepared written testimony of Gail Garceau.

Senator Kathleen G. Sgambati, D. 4: Thank you. Questions? Okay, Kristina Diamond in favor of the bill, but not wishing to speak, Alida Millham, in favor of the bill. I have Denise Brewitt.

Denise Brewitt: Yep.

Senator Kathleen G. Sgambati, D. 4: Our last speaker.

Ms. Brewitt: Good morning. My name is Denise Brewitt and I'm the Executive Director for the Council for Children and Adolescents with Chronic Health Conditions. I wanted to share a story of a family, of a mom who had called me over the summer and told me a story about what had happened to her son.

Obviously, the population of kids with chronic health conditions are at higher risk of the consequences of poor dental health. Her son had, has cardiac issues, and she, getting him to the dentist was something that was difficult to do just because of access in New Hampshire, it's very difficult; she was focused on dealing with the cardiac issues at hand. It was missed by the doctors in Boston. But this child ended up with a severe tooth infection that went into the bloodstream and actually caused this child to be in ICU down in Boston for two weeks because of this infection.

So, it is an investment, it's an investment into quality, you know, care for those kids, but especially the Council would like you to keep in mind the population of kiddos that are even at higher risk, who are contending with chronic health conditions, that the impact, the positive impact that something like this would have on them. Thank you.

Senator Kathleen G. Sgambati, D. 4: Thank you, Denise. Any questions? Thank you very much.

Ms. Brewitt: Yep.

Please see Attachment #12 – Prepared written testimony of Denise A. Brewitt.

Senator Kathleen G. Sgambati, D. 4: Okay. With that, I don't have anyone else signed up, so I will close the hearing on HB 1537.

Hearing concluded at 9:20 a.m.

Respectfully submitted,

Deborah A. Chroniak
Committee Secretary
6-15-10

12 Attachments

ATTACHMENT #1

HB 1537 TESTIMONY

SENATE HEALTH AND HUMAN SERVICES COMMITTEE

April 6, 2010

Good morning Madam Chair and members of the Health and Human Services Committee. For the record, I am Rep. Rich DiPentima representing Rockingham 16 (Portsmouth and Newington) I am a member of the Health, Human Services and Elderly Affairs Committee and Prime sponsor of HB 1537. HB 1537 is legislation that was recommended by a Study Commission established last year as a result of the passing of HB 414. The Commission, of which I was Chairman, was charged to study preventing dental disease among NH children, and our report was submitted to the appropriate parties on Nov 1, 2009. This bill directs the DHHS to amend the State Medicaid Plan to allow reimbursement to appropriately trained primary medical care providers who perform oral screenings and preventive services on Medicaid children age 0-3 years old. This policy is currently in effect in 36 states including every other New England State. The policy issues related to HB 1537 have been well received as evidenced by a very active extended public hearing in the H, HS&EA Committee where no opposition to the bill was received and supporters included Dr. Susan Lynch and the 18-0 vote by this policy committee.

As I stated, HB 1537 is a recommendation of a Study Commission that spent three months researching and hearing from experts from across the country regarding preventing dental disease in children. We heard testimony from 18 individuals and groups with particular expertise and experience in this area. The one issue that presenters to the Commission most often stated would be most effective in reducing dental disease in children was that of having primary care providers (PCP's) conduct oral screenings and apply fluoride varnish and receive Medicaid reimbursement for this service.

Dental cavities are the most prevalent chronic infectious disease in children; however it is almost 100% preventable. Surveys of children in New Hampshire Head Start programs and third grade show that approximately 40% of these children have evidence of treated and/or untreated dental decay. In the past, dental disease in children was considered a minor problem. However, considering the impact on children's overall health, education, pain and suffering and the great financial burden it places on our society, we now recognize this problem to be a major public health concern. An estimated 51 million school hours are lost each year in America because of dental-related illness, and an average of 3.1 days of school are lost per 100 students. In New Hampshire in the years 2007 and 2008 combined, 983 Medicaid eligible children required treatment in hospital operating rooms under general anesthesia for the removal of most or all of their teeth due to untreatable decay. Of these, 519 were children age 0-4. These treatments cost the State General Fund over $1.5 million, not to mention the great

pain and suffering these children endured and that this treatment did not resolve the underlying problem for these children. In addition in CY 2008, 312 children enrolled in Medicaid were seen in Emergency Room for dental conditions. In 2009, DHHS expended $313,245 in emergency departments and operating rooms for children age 0-3. This figure does not include the costs of professional and ancillary services, which when included, will at least double this cost to the state.

So why is this such a problem for Medicaid children age 0-3? Evidence based data has shown that High to Moderate risk children age 0-3 benefit the most from early intervention and prevention services such as fluoride varnish, but very few actually receive this procedure. Why is this the case? There are currently 926 active dentists in NH 787 who are general dentists. Of the total dentists, 625 are enrolled in Medicaid but only 397 actually billed Medicaid in 2009. Furthermore, of those general dentists who do see Medicaid children, very few will see children age 0-3. The reason for this is that they are not trained to work on children this young and are justifiably uncomfortable treating these children. Most importantly, there are only 24 pediatric dentists in New Hampshire, which severely limits the number of young children who see a dentist. In NH, of the approximately 21,000 children age 0-3 on Medicaid, approximately 2,800 have actually seen a dentist. On the other hand, almost every Medicaid child age 0-3 sees a PCP between 9-15 times in their first years of life. This represents currently a great missed opportunity to prevent dental disease in these children. Almost every PCP accepts Medicaid, and they are quite comfortable treating young children. With the appropriate minimal training, that the PCP would be required to obtain at their own expense, many more children would be able to receive the effective preventive benefits of fluoride varnish.

There is another important legal issue to consider. The State was successfully sued in Federal Court by a group of Medicaid clients regarding lack of access to dental care in 1999 (Hawkins v. Commissioner DHHS). The Department entered into a Consent Decree with the plaintiffs in January 2004 agreeing to improve access to dental care for this class of clients. In 2007 and again in 2008 the plaintiffs filed a motion to hold the DHHS in contempt of court for failing to comply with the Consent Decree. These motions was rejected by the court without prejudice. The plaintiffs have again filed a motion on January 21, 2010 to hold DHHS in contempt of court for violations of the Consent Decree. In the Defendant's Memorandum of Law filed with this motion they list a number of actions the Defendant had and has the ability to perform to comply with the court-ordered Decree. Among those actions the Department had and has the ability to do is to pay physicians to perform various services for their pediatric patients who are Hawkins class members. Prevention of early childhood caries and fluoride supplementation are two of the services referred to. In discussions with the attorney representing the Hawkins class members she stated that HB 1537 is in a parallel course with the Hawkins Case. As such,

implementing the benefit provided by HB 1537 would at least partially improve the Departments compliance with the court-ordered Consent Decree.

Lastly, I realize that this committee is primarily concerned with the policy issues of HB 1537. However, especially in these difficult times, anything that looks like it will increase the State's financial burden is received with great skepticism. Please allow me to briefly present my estimate of the potential costs/benefits that would result from adoption of HB 1537. While I am sure you will have questions about my calculations, I am proud to say that Rep. Kurk of the House Finance Committee stated that he thought my analysis was much more realistic than the fiscal information provided by the Department. And as I told the House Finance Committee, it is exactly during difficult times such as these, that we really need to evaluate how we spend every dollar. We must make sure that we receive the most benefit both in the short and long-term, and not to continue spending money in ways that do not solve problems but only provide a temporary band aid solution. HB 1537 accomplishes savings of dollars and unnecessary disease both for the short and long-term benefit of the State's finances and our children's health.

I thank the committee for your patience and allowing me the opportunity to present my case. I am happy to answer any questions you may have.

Estimated Cost Savings From Implementation of HB 1537

Primary Care Medical Reimbursement	Procedure Code	Proposed Fee	#Services/year	Cost/year
Oral Health Assessment and Survey	120/145			
Fluoride Varnish Application	1203/1206	$30	2	$60

Fiscal Impact/Savings

	FY 2012	FY 2013
Projected initial participation and % increase/year	10%*	15%
Number of children receiving prevention	2,172	2,498
Cost/child/year	$60	$60
Expenses Total	$130,320	$149,800
State	$65,160	$74,940
Federal	$65,160	$74,940
Savings		
Projected OR days avoided	25	50
Estimated savings from reduced OR use+	$80,000	$120,000
State	$40,000	$60,000
Federal	$40,000	$60,000

ATTACHMENT #2

Number of children projected to have cavities 40%**	868	911
Restoration cost (2 cavities/child@$150/child)	$130,200	$136,650
Dental care avoided at 38% reduction rate* **	**$49,476**	**$51,927**
Total net Savings including OR	**$129,476**	**$171,927**
State	**$64,738**	**$85,964**
Federal	**$64,738**	**$85,963**
Total Savings /costs after costs of program	**($844)**	**$7,773**
State	**($422)**	**$3,887**
Federal	**($422)**	**$3,886**

*Based on the number of children receiving benefit in NC and ME in first year

**Based on Head Start and 3rd grade surveys of children in NH
***Based on published data of the effectiveness of fluoride varnish in reducing dental decay when done in a PCP office.
+Based on charge data provided by DHHS @ $3,200 per case.

ATTACHMENT # 3

Timothy M. Soucy, MPH, REHS
Public Health Director

Anna J. Thomas, MPH
Deputy Public Health Director

CITY OF MANCHESTER
Health Department

April 6, 2010

Honorable Kathleen Sgambati, Chairman
New Hampshire Senate Health & Human Services Committee
107 North Main Street - Room 302 State House
Concord, New Hampshire 03301

RE: Testimony in Support of HB 1537

Dear Chairman Sgambati and Members of the Committee:

Good Morning, my name is Tim Soucy and I am the Public Health Director for the City of Manchester. I am here today to urge your support for HB 1537, an act allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the State Medicaid program.

According to a recent report issued by the National Maternal & Child Oral Health Resource Center, dental carries continues to be the most common childhood illness in the United States. Nearly half of children ages 2-19 have dental carries in their permanent teeth. Oral health status continues to be serious problem in the City of Manchester, impacting physical, social, economic and psychological health. Poor oral health affects speech, nutrition, self-esteem and a child's ability to learn, particularly in those with lower socioeconomic status.

Health professionals are in a unique position to improve the oral health of Medicaid enrolled children in our State. By completing an oral health risk assessment an applying fluoride varnish during well child visits, then following up with a referral to a dental home, primary care providers can have a positive impact on the overall health of children they serve by ensuring that preventative measures are undertaken beginning early in life.

While I understand the fiscal realities of expanding Medicaid benefits, I believe this bill will provide a long term return on investment, not only financially, but most importantly by improving the oral health, overall health and quality of life for Medicaid enrolled children.

Thank you for your time.

Sincerely,

T M Soucy

Timothy M. Soucy, MPH, REHS

Public Health Director

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ATTACHMENT #4

Senate Health and Human Services Committee
April 6, 2010

Honorable Kathleen Scambati, Chair

The National Academy for State Health Policy in 2008 and 2009 documented that using primary care providers to promote **preventive** oral hygiene and good nutritional habits, refer patients to a dental home by age 1 and to apply fluoride varnish as a proven caries reducing strategy has allowed states to have an opportunity to better serve young children and work toward a goal of ***reducing*** state expenditures on costly restorative care.

Primary care providers see children for well-child visits at least 12 times in the first three years of life as recommended by *Bright Futures, 3rd Edition.* This early and frequent access to infants and toddlers during well child visits presents a valuable opportunity for PCPs to assess a child's oral health, provide preventive oral health services, educate care givers on oral health practices, and refer for a dental visit *without the need for additional work force.*

Data from North Carolina, the state that has provided training and reimbursement the longest, shows that there has been a 38% **decrease** in the need for restorative dental care at age 3 while children on Medicaid had a significant **increase** in dental visits – a win/win situation!

In NH a recent Head Start survey of children showed that 31% had active dental caries and 40% had a history of caries. Nationally the incidence of early childhood caries has increased from 24% to 28% while the incidence of caries in all other age groups has decreased.

The NH Board of Dental Examiners reports that there are approximately 757 practicing dentists but only 24 Pediatric Dentists, none of whom practice in the northern half of the state (Dental Services and workforce in NH 2010, NH Center for Public Policy). There are about 230 practicing pediatricians plus family physicians and nurse practitioners who can be trained to deliver preventive screening oral health services during well child visits.

Virtually all children in NH on Medicaid have a medical home but many lack a dental home. That is why most states (36) including every state in New England except NH have followed the successful strategy of reimbursing PCPs to deliver oral health preventive services as an addition to their well child visits.

Primary Care Providers in New Hampshire have willingly accepted Medicaid children into their practices in spite of significantly reduced reimbursement compared to commercially insured patients *because it's the right thing to do.*

However, asking PCPs to develop new skills, learn additional background information about oral health via computer or hands on training, increase the time for each office visit

(resulting in fewer office visits per day) and pay for staff training, screening tools and fluoride varnish supplies without providing additional reimbursement will not be an effective strategy to bring screening to those who are most in need.

Passing HB 1537 would allow us to join the 36 other states that have found that engaging the medical community in prevention of early childhood caries makes perfect sense to reduce the burden of pain in children while saving significant costs of restorative treatment in the operating room later on.

Suzanne Boulter

Suzanne Boulter, MD

ATTACHMENT # 5

HB 1537

I would like to make the following points in support of HB 1537:

- Tooth decay is the most common preventable childhood disease (US Dept. HHS Oral Health in America – A Report of the Surgeon General, 2000).

- Delayed recognition and treatment can lead to lifelong medical complications and result in costly interventions.

- Preventive oral health practices should begin by age 1 (AAP and AAPD).

- A large and growing body of best practice evidence based data supports the use of primary care providers to perform oral health screenings and preventive services – especially for moderate to high risk children (includes the Medicaid population by definition) and is recommended by the NH Commission to Study Prevention of Pediatric Dental Disease, 2009.

- Changes in nutritional trends over the last 25 years – particularly increased consumption of sweetened beverages have not only increased dental caries but have contributed to our obesity epidemic, (Medicaid population is at higher risk for both of these health problems). Encouraging primary care providers to provide more education on nutrition – especially in infancy and early childhood can help reduce both dental disease and obesity.

- Children on Medicaid are at the highest risk for early dental caries (up to 5X more likely to develop early caries) but least able to access dental services before age 3.

- Primary care providers can provide the following to cost effectively prevent and treat early childhood decay:
    - Oral exams/screening/risk assessment
    - Anticipatory guidance or education
    - Application of topical fluoride

- Cost to train primary care providers and office staff, for needed screening tools and fluoride varnish and for increased office time would be potential barriers to increasing preventive dental care through primary care offices.

- It would be cost effective for NH Medicaid to cover these services in the primary care office for high risk children.

Thank you for your time today and your interest in this important issue.

Susan Lynch, MD

ATTACHMENT #6

NH ORAL HEALTH COALITION

April 6, 2010

To: NH Senate Health, Human Service Committee

Re: HB1537, An Act allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

Good morning Madam Chair and distinguished committee members,

My name is Angela Boyle and I am here today on behalf of the NH Oral Health Coalition. The Coalition is made up of a broad representation of individuals, organizations and agencies concerned with oral health in NH.

Integrating oral health into primary care for young children has been key in preventing dental disease in other states. Here is why that same approach makes sense for NH:

- In 2007 and 2008, there were approximately 1,000 NH children requiring hospitalization for dental needs, and over 1.3 million dollars in state funds expended for hospital operating room charges. This does not include provider fees.
- According to the 2007 CMS EPSDT Participation Report, 900 out of the approximately 17,000 children ages 0-2 enrolled in Medicaid received preventive dental services
- Evidence based practices such as utilizing primary care providers to screen and provide dental preventive services have been instituted in 35 states including every New England State except for NH
- This approach expands the type of providers who can provide access to preventive oral health care services and does not expand the number of eligible recipients or provide new services
- These efforts have shown to reduce the need for corrective dental care on children by 39%
- Each state is federally mandated to provide to any child enrolled in Medicaid with Early, Periodic Screening, Diagnostic and Treatment (EPSDT) services. DHHS is obligated to ensure that dental care takes place at as early an age as necessary according to 42 C.F.R § 441.56 (c)
- HB1537 has no fiscal impact in this budget

The NH Oral Health Coalition strongly supports HB1537 because NH's children are in clear need of basic preventive oral health care aimed at reducing oral disease.

Thank you for the opportunity to provide testimony in support of HB1537. I would be happy to answer any questions.

Respectfully,

Angela Boyle

Angela Boyle, RDH, BS
Director NH Oral Health Coalition

3/3/2009

ANNUAL EPSDT PARTICIPATION REPORT

New Hampshire FY: 2007

				Age Groups						
		CAT.	TOTAL	<1	1-2	3-5	6-9	10-14	15-18	19-20
1.	Total Individuals Eligible for EPSDT	CN	87,286	5,599	10,893	13,949	17,558	19,975	15,257	4,055
		MN	3,392	123	323	548	763	820	644	171
		TOTAL	90,678	5,722	11,216	14,497	18,321	20,795	15,901	4,226
2a.	State Periodicity Schedule			6	4	3	2	5	4	2
2b.	Number of Years in Age Group			1	2	3	4	5	4	2
2c.	Annual. State Periodicity Sched.			6.00	2.00	1.00	0.50	1.00	1.00	1.00
3A.	Total Months of Eligibility	CN	818,086	32,549	105,603	136,005	172,819	197,165	146,169	27,776
		MN	15,081	312	1,253	2,388	3,297	3,927	3,167	737
		TOTAL	833,167	32,861	106,856	138,393	176,116	201,092	149,336	28,513
3B.	Average Period of Eligibility	CN	0.78	0.48	0.81	0.81	0.82	0.82	0.80	0.57
		MN	0.37	0.21	0.32	0.36	0.36	0.40	0.41	0.36
		TOTAL	0.77	0.48	0.79	0.80	0.80	0.81	0.78	0.56
4.	Expected Number of Screenings per Eligible	CN		2.88	1.62	0.81	0.41	0.82	0.80	0.57
		MN		1.26	0.64	0.36	0.18	0.40	0.41	0.36
		TOTAL		2.88	1.58	0.80	0.40	0.81	0.78	0.56
5.	Expected Number of Screenings	CN	83,167	16,125	17,647	11,299	7,199	16,380	12,206	2,311
		MN	1,350	155	207	197	137	328	264	62
		TOTAL	84,517	16,280	17,854	11,496	7,336	16,708	12,470	2,373
6.	Total Screens Received	CN	52,564	13,733	14,665	6,172	6,049	6,758	4,506	681
		MN	675	135	140	100	90	116	78	16
		TOTAL	53,239	13,868	14,805	6,272	6,139	6,874	4,584	697
7.	Screening Ratio	CN	0.63	0.85	0.83	0.55	0.84	0.41	0.37	0.29
		MN	0.50	0.87	0.68	0.51	0.66	0.35	0.30	0.26
		TOTAL	0.63	0.85	0.83	0.55	0.84	0.41	0.37	0.29

ATTACHMENT # 7

ANNUAL EPSDT PARTICIPATION REPORT
New Hampshire FY: 2007

				Age Groups						
		CAT.	TOTAL	<1	1-2	3-5	6-9	10-14	15-18	19-20
8.	Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN	65,887	5,599	10,893	11,299	7,199	16,380	12,206	2,311
		MN	1,318	123	207	197	137	328	264	62
		TOTAL	67,205	5,722	11,100	11,496	7,336	16,708	12,470	2,373
9.	Total Eligibles Receiving at Least One Initial or Periodic Screen	CN	40,589	4,845	7,881	7,401	6,980	7,863	4,932	687
		MN	708	84	127	123	117	146	94	17
		TOTAL	41,297	4,929	8,008	7,524	7,097	8,009	5,026	704
10.	Participant Ratio	CN	0.62	0.87	0.72	0.66	0.97	0.48	0.40	0.30
		MN	0.54	0.68	0.61	0.62	0.85	0.45	0.36	0.27
		TOTAL	0.61	0.86	0.72	0.65	0.97	0.48	0.40	0.30
11.	Total Eligibles Referred for Corrective Treatment	CN	0	0	0	0	0	0	0	0
		MN	0	0	0	0	0	0	0	0
		TOTAL	0	0	0	0	0	0	0	0
12a.	Total Eligibles Receiving Any Dental Services	CN	38,205	24	1,477	6,359	10,306	11,286	7,635	1,118
		MN	905	0	27	123	239	280	203	33
		TOTAL	39,110	24	1,504	6,482	10,545	11,566	7,838	1,151
12b.	Total Eligibles Receiving Preventive Dental Srvcs.	CN	34,212	19	864	5,779	9,735	10,421	6,583	811
		MN	737	0	18	108	207	237	150	17
		TOTAL	34,949	19	882	5,887	9,942	10,658	6,733	828
12c.	Total Eligibles Receiving Dental Treatment Srvcs.	CN	17,513	1	125	1,739	4,681	5,646	4,621	700
		MN	379	0	5	38	91	110	113	22
		TOTAL	17,892	1	130	1,777	4,772	5,756	4,734	722
13.	Total Eligibles Enrolled in Managed Care	CN	0	0	0	0	0	0	0	0
		MN	0	0	0	0	0	0	0	0
		TOTAL	0	0	0	0	0	0	0	0
14.	Total Number of Screening Blood Lead Test	CN	4,701	118	3,726	857				
		MN	55	1	39	15				
		Total	4,756	119	3,765	872				

ATTACHMENT # 8

II.D.1.b. Coordinate efforts among oral health providers, school administration, school nurses, school health educators, alcohol and tobacco prevention task forces, etc., to implement comprehensive educational programs regarding the dangers of tobacco and alcohol use.

II.D.1.c. Educate primary care providers regarding the importance of early detection and treatment of oral and pharyngeal cancers.

II.D.1.d. Enlist oral health and primary care providers to participate in alcohol and tobacco education and cessation programs.

II.D.1.d.(i). Provide continuing education to oral health and primary care providers regarding effective approaches to reduce the use of alcohol and tobacco.

Goal

II.E. Reduce the incidence of oral and facial injuries.

Objective

II.E.1. Recommend the requirement of the use of face-masks and mouthguards in all school and other sports programs.

Strategy

II.E.1.a. Coordinate efforts among school personnel, coaches, and recreation programs regarding the importance of injury prevention.

Principle

III. Build an effective health infrastructure that meets the oral health needs of all and integrates oral health effectively into overall health.

Goal

III.A. Enhance the existing workforce to meet the diverse oral health needs of all New Hampshire residents.

Objective

III.A.1. Maximize the capacity of the oral health workforce to address the needs of the population.

Strategies

III.A.1.a. Establish a task force comprised of appropriate leaders and policymakers to monitor and address the changing needs of the population.

III.A.1.a.(i). Conduct periodic evaluations of the workforce model, and refine as necess to address the evolving needs and demands of the population.

III.A.1.a.(ii). Develop flexibility in workforce policies to assure that population needs ca be met in a timely and effective manner.

III.A.1.b. Develop and promote career counseling at all New Hampshire high schools to encourage students to pursue careers in oral health.

III.A.1.c. Recruit more dentists, especially those who see high risk and vulnerable populatio such as the economically disadvantaged, young children, the elderly, the developmentally disabled, and those with HIV/AIDS, to offset a provider shortage in New Hampshire.

III.A.1.c.(i). Pursue the potential to fund positions for New Hampshire students at New England dental schools.

III.A.1.c.(ii). Continue to provide loan repayment to dentists willing to serve New Hampshire's indigent and high risk populations.

III.A.1.d. Pursue the use of dental externs and residents by establishing training programs at safety net facilities.

III.A.1.e. Expand the number of dental hygienists in New Hampshire working in both public health and private office settings.

III.A.1.e.(i). Expand the facilities and training program for dental hygienists at the New Hampshire Technical Institute, and maximize their use.

III.A.1.e.(i).(a). Create a partnership with the New Hampshire Dental Society to fund the training program.

III.A.1.e.(ii). Recruit more dental hygienists to New Hampshire.

III.A.1.e.(ii).(a). Pursue state and private foundation support for recruitment and training of public health hygienists.

III.A.1.f. Pursue the use of new dental and non-dental providers to enhance the oral health workforce.

III.A.1.f.(i). Create the capacity to use expanded function dental assistants (EFDA) in dental practices and safety net facilities to improve productivity.

III.A.1.f.(ii). Use primary medical care practitioners to provide oral assessment and preventive services.

III.A.1.f.(ii).(a). Establish training and protocols for basic oral examination for primary care medical providers.

III.A.1.f.(iii). Build the capability among prenatal care providers to provide patients with oral assessment, education and appropriate referral for oral health services.

III.A.1.f.(iv). Develop a new professional category of Oral Health Educator.

Objective

III.A.2. Integrate, improve, expand and sustain the oral health component of the healthcare safety net.

Strategies

III.A.2.a. Advocate for funding for those organizations that provide oral health services to high risk and underserved populations from New Hampshire's public and private funders.

III.A.2.b. Pursue federal and private foundation funding to augment state-funded oral health initiatives.

III.A.2.c. Encourage all community health centers to provide oral health services.

III.A.2.d. Encourage private dentists and hygienists to provide services within the safety net.

III.A.2.e. Utilize the state loan repayment program for dentists and hygienists who agree to practice in underserved areas.

III.A.2.f. Encourage New Hampshire hospitals to play a major role in supporting the safety net.

III.A.2.f.(i). Advocate that all New Hampshire hospitals participate in establishing, financing and maintaining safety net oral health services in their communities.

III.A.2.f.(ii). Encourage New Hampshire hospitals to prioritize oral health services in the allocation of community benefit dollars.

III.A.2.f.(iii). Advocate that all New Hampshire hospitals develop and maintain a dental on-call system through their Emergency Departments.

New Hampshire Oral Health Plan:

A Framework for Action

Coalition for New Hampshire Oral Health Action

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A Framework for Action

Coalition for New Hampshire Oral Health Action

July 2003

July 2003

Dear Colleague,

Today, oral diseases affect millions of Americans and dental caries (tooth decay) is the single most common childhood disease. Too often we ignore the fact that good oral health is essential to good health overall, and fail to recognize that oral health problems contribute to other diseases such as heart disease, diabetes and stroke, and are associated with serious problems for newborns. And yet, what is most striking is that most oral disease is preventable.

The Coalition for New Hampshire Oral Health Action was convened by the Endowment for Health and the New Hampshire Department of Health and Human Services in July 2002 to develop a statewide plan to mobilize resources and combat this "silent epidemic". Representing numerous agencies, organizations and professions Coalition members assembled not just to find solutions to New Hampshire's oral health problems, but to take action to bring those solutions to life. The Coalition often engaged in intense debate before coming to consensus on a framework for action. This collaborative spirit overrode individual agendas, as members recognized that broad-based cooperation would be essential to overcoming barriers to achieving good oral health for all New Hampshire citizens. We would like to thank Coalition members for their dedication and commitment to the process.

We are also grateful for the insights and assistance from our consultants, Dr. Burton Edelstein and Dr. Caswell Evans, who generously devoted their valuable time and effort to providing the Coalition with expertise, wisdom and information from a national perspective.

Finally, we would like to thank Wendy Frosh for her numerous contributions to the process. It was Wendy who facilitated the meetings, guided the process, helped us to achieve consensus, and ultimately pulled together the vision of Coalition members into this plan.

The work of the Coalition is not over. Members have committed to working on the implementation of the plan, and have extended invitations to other key stakeholders to contribute to the process. The goals, objectives and strategies enumerated in this document will be the basis for a work plan with responsibilities and timelines assigned.

The Framework for Action is intended to be a "living document" – one that will be revisited and modified as implementation proceeds. We are especially pleased that the publication of this plan coincides with the release of the Surgeon General's National Call to Action to Promote Oral Health. On behalf of the Coalition for New Hampshire Oral Health Action, we invite you to join us in this critical public health initiative.

Sincerely,

William J. Kassler, MD, MPH
State Medical Director
Department of Health and Human Services

Mary Vallier Kaplan
Program Director
Endowment for Health

Coalition for New Hampshire Oral Health Action Participants

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Project Director and Managing Editor, *Oral Health in America: A Report of the Surgeon General*

Wendy Frosh, Principal, Healthcare Management Strategies

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Sue Fulton, Endowment for Health

Peg LePage, Endowment for Health

Table of Contents

1. Executive Summary

New Hampshire has been ranked as one of the healthiest and wealthiest states in the nation, and is seen by many as relatively homogeneous and problem free. This veneer belies the fact that access to oral health care varies greatly across the state, and oral diseases are a devastating problem among a significant percentage of New Hampshire residents, affecting their overall health and ability to work and learn. While much oral disease is preventable, many in New Hampshire lack access to the basic services that could help them avoid oral pain, infection and dysfunction, dental caries (tooth decay), tooth loss and other oral health problems. Over the past decade, efforts have been made to address these concerns with some measure of success. But these initiatives have had limited effectiveness because of the lack of a comprehensive, coordinated approach among funders and policymakers to addressing the problem.

Responding to a growing concern regarding the oral health of New Hampshire's residents, the New Hampshire Department of Health and Human Services (DHHS) and the Endowment for Health (EFH) collaboratively convened the Coalition for New Hampshire Oral Health Action in July of 2002. The Coalition accepted as its charge the task of developing a blueprint for decision-making, an oral health plan for the state.

The Coalition for New Hampshire Oral Health Action was designed to be broadly representative of the individuals and entities concerned with oral health. Its members included representatives from the oral health community, the medical community, the legislature, education, advocacy groups and the insurance industry, as well as from the New Hampshire DHHS and the Endowment for Health. Its charge was to develop a plan that would address the oral health needs of all New Hampshire residents and communities and the conditions and opportunities specific to New Hampshire, and create a model for action that would build upon the oral health improvement activities already underway across the state.

To begin the process of plan development, the Coalition embarked on an exploration of the elements that constitute the landscape of oral health. These components were categorized as Prevention, Health Promotion, Education and Counseling; Workforce; Financing; Safety Net; Integrating Functions; and Advocacy, Policy and Politics.

To encourage public input to the process, a series of six community "listening sessions" were held across the state. The goal of these sessions was to communicate about the plan development process, elicit community perspectives on local oral health problems and solutions, to prepare the ground for community implementation initiatives, and to incorporate community perspectives into the oral health plan. In addition to the research conducted within the state, the Coalition reviewed a broad spectrum of national initiatives regarding oral health, such as the Surgeon General's report, *Oral Health in America,* and *Healthy People 2010.*

Throughout the planning process, the Coalition for New Hampshire Oral Health Action operated with a set of underlying premises regarding the promotion of oral health and the provision of dental care: While health and health care are ultimately family and community considerations and New Hampshire's regions and communities have unique capacities and constraints, state level activity can support communities in improving oral health and dental care. It was determined that the resulting

plan, therefore, should not only identify a "standard" level of oral health for all residents, but should also articulate priorities for both statewide and community-level action; identify tools and resources to address oral health needs; coordinate and support existing community-based systems; and empower individuals to access and utilize available resources.

It was acknowledged by the Coalition that while there are common underlying issues and problems across New Hampshire, variation exists – in terms of unique needs, available resources and competencies – from region to region, and community to community. This means that there is the need to identify statewide initiatives that will have the capacity to benefit all communities – such as improving Medicaid reimbursement and establishing funding mechanisms for local system development – knowing that these initiatives may create different outcomes community by community.

Using the principles identified in the Surgeon General's report, *Oral Health in America,* as its framework for articulating a plan of action, the Coalition developed a vision for New Hampshire and strategies to reach that vision (the details of which follow in the body of this report). Coalition members committed to the responsibility of implementing the plan and monitoring the success of those initiatives undertaken.

It is not the intent of this report to provide a comprehensive review of the oral health status of New Hampshire's residents, nor a restatement of the scope of the problem. Instead, on the following pages, the Coalition for New Hampshire Oral Health Action offers a vision and discussion of what actions will be necessary to bring oral health and its positive impact on well-being, to the residents of New Hampshire. That there are disparities in the oral health status of New Hampshire residents is undisputed. Finding ways to reduce those disparities is the subject of this report.

Vision

Residents of New Hampshire will have the opportunity to achieve and maintain oral health through access to an effective system of health services which promotes appropriate health behaviors.

These services, which include assessment, prevention, health promotion, education, counseling, and treatment, will be provided through an integrated system of health care that assures accessibility, affordability, high quality, appropriateness to individuals' needs, and responsiveness to individuals' circumstances.

Recommendations

Principle

I. Change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health.

Goal

I.A. Increase public perception of the importance of good oral health as a component of overall health.

Objectives

I.A.1. Develop a statewide oral health awareness and education campaign.

I.A.2. Integrate oral health with general medical care.

I.A.3. Integrate comprehensive oral health curricula in general health curricula and promote in all New Hampshire schools.

Principle

II. Apply science effectively to improve oral health.

Goal

II.A. Assess the oral health status of New Hampshire residents.

Objective

II.A.1. Develop and maintain a comprehensive epidemiological oral health surveillance system to identify, investigate and monitor oral health and oral health services.

Goal

II.B. Reduce the burden and progression of oral diseases in New Hampshire by integrating best available science and evidence-based treatment into clinical practice and policy.

Objective

II.B.1 Access and disseminate leading edge information on oral health science.

Goal

II.C. Reduce the incidence of dental caries through evidence-based public health interventions.

Objectives

II.C.1. Maximize the benefits of fluoride in preventing and controlling dental caries.

II.C.2. Implement and maintain the capacity for a statewide school-based sealant program.

Goal

II.D. Increase early detection and reduce the incidence of oral and pharyngeal cancers.

Objective

II.D.1. Support efforts to reduce tobacco and alcohol use among New Hampshire residents.

Goal

II.E. Reduce the incidence of oral and facial injuries.

Objective

II.E.1. Recommend the requirement of the use of face-masks and mouthguards in all school and other sports programs.

Principle

III. Build an effective health infrastructure that meets the oral health needs of all and integrates oral health effectively into overall health.

Goal

III.A. Enhance the existing workforce to meet the diverse oral health needs of all New Hampshire residents.

Objectives

III.A.1. Maximize the capacity of the oral health workforce to address the needs of the population.

III.A.2. Integrate, improve, expand and sustain the oral health component of the health care safety net.

Principle

IV. Remove known barriers between people and oral health services.

Goal

IV.A. Eliminate barriers and enhance access to good oral health.

Objectives

IV.A.1. Create system-level improvements to treat high risk populations such as children, the elderly, uninsured adults, the developmentally disabled, the mentally ill and those with HIV/AIDS.

IV.A.2. Enhance the competency of the oral health workforce to treat high risk populations.

IV.A.3. Build a care coordination and case management system especially for those at high risk.

IV.A.4. Improve access to dental insurance among all sectors of the population.

Principle

V. Use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.

Goal

V.A. Further integrate the efforts between the public and private sectors to address the oral health needs of the residents of New Hampshire.

Objectives

V.A.1. Create a statewide clearinghouse to serve as a resource for information on existing oral health programs, technical support, funding consultation and successful public health models.

V.A.2. Promote regional and community-based collaborative efforts among agencies, organizations and individuals to address oral health needs.

V.A.3. Monitor the implementation of the New Hampshire Oral Health Plan.

V.A.4. Review and revise the New Hampshire Oral Health Plan as necessary.

2. Introduction

The Surgeon General's report, *Oral Health in America,*[1] defines oral health as more than healthy teeth, more than being free from disease. Oral health is a positive condition that is integral to general health and well-being. An individual who does not have the ability to perform certain essential functions – to speak, taste, chew and swallow – may have compromised ability to work, learn or function effectively within the community. The Surgeon General goes further to say that oral health is not only essential to general health, but can be achieved by everyone. However, while we have made substantial improvements in the nation's oral health over the past several decades, there continues to be a significant segment of the population for whom oral health remains elusive.

New Hampshire has been ranked as one of the healthiest and wealthiest states in the nation, and is seen by many as relatively homogeneous and problem free. This veneer belies the fact that access to oral health care varies greatly across the state, and oral diseases are a devastating problem among a significant percentage of New Hampshire residents, affecting their overall health and ability to work and learn. While much oral disease is preventable, many in New Hampshire lack access to the basic services that could help them avoid oral pain, infection and dysfunction, dental caries (tooth decay), tooth loss and other oral health problems. Over the past decade, efforts have been made to address these concerns with some measure of success. But these initiatives have had limited effectiveness because of the lack of a comprehensive, coordinated approach among funders and policymakers to addressing the problem.

Because of the far reaching impact of these problems, the New Hampshire Department of Health and Human Services and the Endowment for Health have both identified improving New Hampshire's oral health as a priority for action. Citing their mutual commitment to reducing the devastation of oral disease, New Hampshire DHHS and the Endowment for Health worked collaboratively to convene a statewide coalition to develop an oral health plan for New Hampshire, which would identify and prioritize the actions necessary to address the problems and serve as a blueprint for decision-making.

1. US Department of Health and Human Services. *Oral Health In America: A Report of the Surgeon General.* Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

3. The Oral Health Plan Development Process

The Coalition for New Hampshire Oral Health Action was convened by the Endowment for Health and the New Hampshire Department of Health and Human Services in July of 2002. It was designed to be broadly representative of individuals and entities concerned with oral health, and included members from the oral health community, the medical community, the legislature, education, advocacy groups and the insurance industry, as well as from the New Hampshire DHHS and the Endowment for Health. Its charge was to develop a plan that would address all New Hampshire residents and communities, the conditions and opportunities specific to New Hampshire and create a model for action that would add value to the oral health improvement activities already underway across the state.

By assembling these individuals from across New Hampshire, the conveners sought to build commitment, raise awareness and promote collaboration among key stakeholders whose participation in both the planning and implementation processes would be critical. Both the Endowment and the New Hampshire DHHS participated actively in the Coalition's proceedings on an equal footing with other invitees. Nationally-recognized oral health policy experts were retained to serve as consultants to the Coalition and an experienced facilitator and advocate for oral health service and policy issues served as Project Director and meeting facilitator. This enabled the assembled members to engage in lively and often provocative discussion. All Coalition members were asked to commit to the intensive six-month process.

Discussion at the initial session led to refinement and elaboration of the original charge. Consensus was quickly reached as the Coalition agreed to pursue the development of a plan that would address both oral health and dental care; be realistic and sustainable; capitalize on all available resources; include measurable goals and outcomes; acknowledge the unique conditions across New Hampshire; utilize the best available national and state information and data; and provide flexibility to meet local/community needs.

To begin the process of plan development, the Coalition embarked on an exploration of the elements that comprise the landscape of oral health. These components, which will be explored in more detail in the Findings section of this report, were categorized as

- Prevention, Health Promotion, Education and Counseling
- Workforce
- Financing
- Safety Net
- Integrating Functions
- Advocacy, Policy and Politics

Prevention, Health Promotion, Education and Counseling

The focus of the Coalition's discussion was on the potential for true disease prevention through widespread public and professional education regarding the importance of oral health to general health and interventions such as community water supply fluoridation and sealants. Also addressed was the opportunity for effective disease management through early intervention, education, counseling and

services designed to empower the individual to take action to promote good oral health, such as programs to reduce transmission of oral infection from mother to infant and reduce the incidence of "baby bottle decay" among infants and toddlers. As a principle, the Coalition endorsed the idea that types and intensities of interventions be matched to risk levels for disease in both individuals and populations.

Workforce

The Coalition dissected the issue of workforce adequacy, looking at current and projected numbers of oral health professionals; their types, diversity and distribution across the state; their competency training for the unique needs of the underserved populations; the potential to utilize "non-dental" providers to expand the reach of oral health services; and the interactions between and among providers of oral health services.

Financing

In this session, Coalition members examined the design and experience of the state's Medicaid fee-for-service program, Healthy Kids Gold; the State Children's Health Insurance Program (SCHIP), Healthy Kids Silver; and the managed care program, Northeast Delta Dental (NEDD) Kids. They also reviewed the commercial insurance market and self-pay components of the financing system.

Safety Net

Defining the safety net as the providers of care who have a priority commitment to deliver affordable [oral] health services to vulnerable and underserved populations; where people with economic, social and cultural barriers to care can obtain [oral] health services, the Coalition considered the experience and potential of programs delivered by Community Health Centers, school-based programs and hospital-based programs.

Integrating Functions

Coalition members explored the role of data collection, reporting and evaluation in building an accountable oral health system. Care coordination and case management were also considered as the Coalition discussed the functions that are required to link and integrate the components of an oral health system.

Advocacy, Policy and Politics

Acknowledging the essential role of advocacy, policy and politics in implementing an oral health plan, the Coalition members considered the approaches to necessary policy development and building political will to support required policy and funding changes.

Public Input to the Planning Process

A series of six community "listening sessions" were held across the state to encourage public input to the planning process. The goals of these sessions were to communicate about the plan development process, elicit community perspectives on local oral health problems and solutions, to prepare the groundwork for community implementation initiatives and to incorporate community perspectives into the Oral Health Plan. The listening sessions were held in Concord, Dover, Keene, Lancaster, Manchester and Nashua, in collaboration with community-based health consortiums, Healthy Manchester

Leadership Council, Greater Nashua Healthy Community Collaborative, Alliance for Community Health, Strafford Network, North Country Health Consortium, Monadnock Partnership and Pilot Health.

While specifics varied from locale to locale, among the observations expressed by those in attendance at these meetings several consistent themes emerged. Although these perceptions may not be validated by data, their repetition from site to site was noteworthy.

- There was a perception that the general population does not value oral health as a priority.
- Many said that populations at risk for increased incidence of oral diseases because of a lack of access to prevention and treatment include children, elderly, low income, disabled, and homeless.
- It was suggested that there is a shortage of dental personnel – dentists, hygienists, and assistants – available to treat not only the indigent and high risk populations, but also the general population, as evidenced by the fact that in many areas of the state there is a lengthy waiting period for treatment, regardless of source of payment.
- Many felt that general dentists aren't adequately trained to handle the extreme need in the indigent population and often don't know how to manage this need with the limited resources available.
- It was suggested that proposed New Hampshire legislation and regulation regarding treatment and environmental concerns may further impede access by putting constraints on dental practice.
- Many expressed concerns that business and industry do not recognize the impact of poor oral health on economic performance.
- It was the sense of many that low Medicaid payment for dental services continues to be a barrier to dentists' participation in the program.
- Concerns regarding the sustainability of publicly-funded programs were expressed.
- It was noted that the fact that fluoridation of drinking water is not consistent throughout New Hampshire has contributed greatly to the oral health disparities within the population.
- Many felt that public education regarding the importance of good oral health needs to be a priority.
- The success of school-based programs in introducing good oral health behaviors in children was cited.
- It was suggested that communication between the Legislature and oral health professionals should be improved.

Stakeholder Input to the Planning Process

While the Coalition members actively participated in the planning process, each was invited to discuss his or her views with the Project Director individually and in confidence. The goal of these meetings was to ensure that every member was able to express individual priorities and/or concerns, and contribute to the process and substance of the plan. These meetings generated a short list of issues which required additional discussion at Coalition meetings. Of particular concern were topics including:

At-risk populations – children, the elderly, the developmentally disabled, and those with HIV/AIDS;
Workforce – numbers, capacity and roles;
Fluoride and sealants;
Sustainability of safety net services;
Medicaid reimbursement; and
Plan implementation.

As planning sessions continued, these topics were reopened and discussed in more detail. Concerns and controversies punctuated the dialogue, and led to a fuller appreciation of individual opinions.

4. Findings of the Coalition for New Hampshire Oral Health Action

The Coalition met regularly over a six-month period in an effort to review key issues in oral health. Their meetings were focused topically on the elements that comprise the oral health landscape:

- Prevention, health promotion and education
- Workforce
- Financing
- Safety Net
- Integrating Functions
- Advocacy, policy and politics

Prevention, Health Promotion and Education

Prevention, health promotion and education clearly represent the most cost-effective means to improving New Hampshire's oral health. Not all individuals and populations are at the same risk for oral diseases, therefore a principle of the Coalition's plan is to target intensity and types of interventions to match the levels of risk. Initiatives such as early intervention, disease management and risk-based interventions need to be directed to the individuals and populations at highest risk.

The importance of fluoridation as a preventive measure is widely recognized and long-standing. Sixty-six percent of the US population who are on public water supplies receives fluoridated water. This represents 58% of the total US population. In New Hampshire, while two thirds of the population uses public water supplies, only 10 communities have fluoridated their water supply. This results in only 25% of the total New Hampshire population having access to fluoridated water. When assessing the percentage of a state population on public water supply receiving fluoridated water, New Hampshire ranks tenth lowest in the country.

The Coalition recognized that to fluoridate 65% of those communities who use public water supplies, the Healthy New Hampshire 2010 goal, tremendous political will and grassroots support will be required. Absent universal fluoridation across the state, other interventions such as the prescribing of fluoride by primary care medical providers and school-based fluoride programs in communities where residents do not have access to fluoridated public water supplies take on added importance, but it will be necessary to simplify the process of well-water testing in order to facilitate the prescribing of fluoride by medical providers.

Application of sealants on the teeth of school-aged children has also been proven effective in the prevention of some types of dental caries. Very few school-based sealant programs are underway in New Hampshire, although oral health education, screening and cleaning programs are in place in numerous school districts across the state. The Coalition deliberated at length regarding the most effective approach to provide sealants to those school-aged children who do not access regular dental care. In New Hampshire, although hygienists can place sealants on the teeth of children who have been examined by a dentist, the availability of financial resources to reimburse dentists to provide those examinations was a concern. While the majority of Coalition members noted that this could limit the number of high risk children who receive sealants through school-based programs,

the pursuit of an expansion of school-based sealant programs through the use of volunteer dentists, rather than a change in the rules regarding supervision was agreed to as a compromise. The New Hampshire Dental Society offered to coordinate this volunteer initiative, in an effort to not only expand the reach of this program, but also to expose dentists to the extent of oral disease in school-aged children. The Coalition also agreed to monitor the success of this initiative and to pursue other approaches if this does not generate the necessary delivery of sealants to at-risk children.

Education and health promotion will also need to play a major role in improving New Hampshire's oral health. A common thread throughout the planning process was the acknowledgement that a significant number of New Hampshire residents do not value oral health. Many people believe that the loss of teeth is a natural, unavoidable process, and that treatment, let alone prevention, screening, and early diagnosis, is unnecessary. It will take an enormous public health education effort to begin to change that mentality, but an effort that the Coalition deemed critical.

Workforce

Much of the discussion regarding workforce focused on the perceived shortage of dentists in New Hampshire. Currently there are just under 900 licensed dentists in the state, the majority of whom, like the population, are concentrated in the southern tier, although within that geography there are populations who are relatively underserved. Of that number, two-thirds are general dentists, and one-third, specialists. Almost 50% of the New Hampshire Dental Society's members are over 50 years old. The number of dentists is projected to begin declining over the next five years, as the number of dentists graduating from dental schools is outstripped by those retiring from active practice. As there are no dental schools and few residency training slots in New Hampshire, recruitment remains a significant challenge, as dentists commonly locate their practices near where they are educated. The number of dentists who actively treat New Hampshire's highly vulnerable populations – children, developmentally disabled, the elderly, and those with HIV/AIDS – is relatively small.

Registered Dental Hygienists are also in short supply in New Hampshire. There is one training program with the capacity to graduate 28 hygienists each year. While federal projections anticipate an increase in the number of hygienists over the next five years, currently, there is reported difficulty in filling positions in the public health sector as well as those in private practice. Hygienists are able to provide an array of key preventive services including fluoride treatments and sealants, but some of those services must be provided under supervision of a dentist. Previously, the Dental Society offered financial resources to increase capacity to train hygienists at the state's Technical Institute, but corresponding funding was eliminated from the state's budget. This approach has recently been reinitiated.

Another member of the oral health workforce, the Dental Assistant, was discussed by the Coalition in some detail. No formal training program or licensure is required for those in this field, except for certification to expose radiographs. New Hampshire does have one formal education program for Dental Assistants, but many receive their training "chair-side," on the job. Various states have enabled the creation of a "new" category of provider – the Expanded Function Dental Assistant (EFDA) – to enhance dentists' productivity. It was suggested that the Coalition investigate the potential for moving in that direction. The relatively short training period and cost of labor may provide a cost-effective approach to addressing the impending reduction in dentist-to-population ratios.

In addition to the traditional oral health workforce, the Coalition examined the potential for utilizing "non-dental" providers to perform certain oral health functions. The merits of integrating

oral screening and oral health promotion into general medical care – health history, physical examination and health counseling – were widely accepted as the discussions focused on the feasibility of pediatricians, family practitioners, nurse practitioners and other primary medical care providers providing oral screening, fluoride varnishes, and other preventive interventions. The Coalition considered the creation of training protocols for these non-dental providers as a means to improve access to basic preventive oral health care, and debated the financial impact of expanding the workforce in this manner.

As the Coalition members evaluated the roles and functions of the traditional and non-traditional workforce members, they discussed the need for a new type of provider, one who had a combination of skills – those of a hygienist, a case manager and a health educator. Using the Certified Diabetes Educator as the model for this new provider, the Coalition considered the formalization of the role of an Oral Health Educator.

Again moving beyond the bounds of the traditional oral health workforce, the Coalition considered the merits of using those who are in day-to-day contact with children – parents, day care workers, educators – as promoters of oral health and oral health education.

The Coalition concluded that flexibility is a desirable component of workforce policy. Creative methods must be developed to assure an "elastic" workforce that can adjust to the changing needs of the population in a timely and effective manner. Creating a subgroup of appropriate leaders and policymakers to monitor and address these issues was deemed a priority.

Financing

Financing for oral health services in New Hampshire comes from a number of sources – commercial dental insurance, individual payment, Medicaid (traditional fee-for-service, as well as voluntary managed care) and the State Children's Health Insurance Program (SCHIP). Benefits under Medicaid are federally mandated for children, with treatment for adults limited to emergency care for pain and infections.

The Medicaid program for oral health covered 115,864 New Hampshire residents in Fiscal Year 2002. While 49.2% of licensed New Hampshire dentists were contracted Medicaid providers in 2001, 34.8% were active Medicaid providers (having seen at least one patient during CY01), only 7.7% were high volume providers (treating 100 or more patients in CY01). Total expenditures in FY02 on the Medicaid fee-for-service dental program were $4,584,933, with the vast majority (89.5%) spent on care for the 56,000 children enrolled in the program's fee-for-service and voluntary managed care plans. Dentists' participation in Medicaid has been hampered by the limited reimbursement for services, the majority of fees for which have not changed since 1994, and a burdensome administrative process.

The Medicaid program for oral health has evolved in a number of significant ways over the past several years. Though no new funding has been allocated by the legislature, the state convened a Dental Policy Advisory Committee, which conducted an evaluation of Medicaid reimbursement rates. In January 2000, they recommended increasing fluoride treatments to twice a year, a reimbursement rate increase for 12 procedures (predominantly those that are preventive and widely performed). Effective July 1, 2003, 27 codes were increased by an average of 64%. Also in response to suggestions from the dental community, many of the administrative components of the program have begun to be streamlined.

Additionally, in August, 2000, the state initiated a voluntary managed care program, NEDD-Kids, which was subcontracted to Northeast Delta Dental (NEDD) and administered through Anthem. Almost 90% of New Hampshire licensed dentists participate with Northeast Delta Dental, greatly

increasing access for children in this Medicaid program. The initial enrollment of 3,945 – approximately 7% of the total children enrolled in Medicaid – more than doubled in the program's two years of operations and expenditures on this population in FY02 – for the 8,717 enrolled – were in excess of $3,500,000, with reimbursement for care limited to $2,500 per year per child. In July 2003, the NEDD program was eliminated when DHHS did not renew its contract with Anthem for the voluntary managed care program.

The SCHIP dental program, Healthy Kids Silver, is also handled by NEDD through a contract with New Hampshire Healthy Kids Corporation. With 5,167 children enrolled as of August, 2002, SCHIP dental spending was approximately $1,000,000 (FY02). This program, for children from modest income families who have been uninsured for at least six months, has a family income-based premium, subsidized with both state and federal funds. Benefits through the program are limited to $600 per year.

A compilation of results from these programs shows that New Hampshire is making progress in providing oral health services to low income children, although the majority of covered children do not access dental care in a year. But a complete analysis of the program data has yet to be done, and the true impact on enrollees' oral health status remains unanswered.

Evidence that there is a preference among dentists for treating the Medicaid population through NEDD Kids indicates that reimbursement and simplified administration are drivers in ensuring access to care. This puts pressure on the state to increase fees in the traditional fee-for-service program, a move that will require legislative initiative. In addition to addressing the direct costs of its Medicaid programs, the state is also looking at ways to improve the effectiveness of services delivered by enhancing the case management and care coordination system used by program participants.

Safety Net

The safety net was defined by the Coalition as those care providers who have a priority commitment to deliver affordable oral health services to vulnerable and underserved populations. They noted that because both state and private funding is limited, resources for care are often constrained. The result is that the safety net is as vulnerable as many of its patients and cannot function as a true system, where care is integrated and coordinated among the various providers.

The Coalition examined the components of New Hampshire's safety net for oral health services. There are eight oral health clinics in the state – some community-based, some hospital-based, and others integrated into New Hampshire's community health centers – that provide a range of oral health care to the indigent. Many of these clinics also provide school-based services, while other school-based services are delivered as free-standing programs. Hospital emergency departments deliver services as well, to those with economic, social and cultural barriers to obtaining care, although the nature of these services is generally limited to treating pain and infection through medication. The NH Technical Institute serves approximately 1,200 elderly on an annual basis, providing prophylaxis, diagnosis and restorative care.

The Coalition also noted that many New Hampshire dentists provide pro bono care in their offices. Often the work of these dentists is coordinated through a case management system or community program, but many dentists offer services directly to specific at-risk patients. Some private practices have been developed and grant-funded by local health collaboratives or private entities to extend care to the indigent.

In reality, New Hampshire's safety net is unstructured and discontinuous, and ultimately unable to adequately serve the growing number of individuals in need of oral health services.

Integrating Functions

The Coalition reflected at length on the importance of a "system" of oral health care services. The ideal system would provide a continuum of services – from prevention and health promotion through restorative care – and would enable a user to move seamlessly among its components, regardless of his or her point of entry. Comprised of a variety of programs and clinicians – school-based screenings, private practitioners, community health centers, etc. – these components would be integrated through care coordination, reporting and accountability.

The group differentiated between disease management – managing the risk for and process of a disease; and care coordination – assisting an individual to receive necessary services, such as social, medical, educational, transportation, and translation by linking that individual with provider(s), so that the he or she can function within a community at an optimal level. The importance of integrating oral health into the health and human services system – for care coordination as well as service delivery – was reiterated in those discussions. Additionally, it was noted that care coordination could often be extremely effective in promoting health and encouraging compliance through counseling and education.

With regard to reporting and accountability, it was the sense of the Coalition that data were needed for two distinct purposes: to document progress in addressing unmet need, and to improve the efficacy of oral health interventions. The importance of "need" data was deemed essential as the basis for programmatic decision-making, as well as for educating the public (and the legislature) about the extent of the problem.

The state's Oral Health Program has conducted a representative oral health survey of New Hampshire's population. For third grade children, the survey measures the number of children with untreated decay, history of decay and the number of children with sealants. For adults, incidence of oral cancers, tooth loss, teeth cleaning and dental visits are measured, and the number of communities with fluoridated water is tracked. Annual assessments of established school, hospital and community-based dental programs' data are also performed. And because of the sample size, much of the data cannot be extrapolated to the local level.

Advocacy, Policy and Politics

The roles of advocacy, public policy and politics in moving the oral health agenda forward was deliberated by the Coalition. It was determined that there is a clear need to build constituencies concerned and committed to improving New Hampshire's oral health – within the general public, the dental and medical professions, and the legislature, as well as among advocacy groups who are already skilled in promoting the goals of their constituents. Shaping public policy to recognize the importance of oral health will also be critical to attaining the objectives in the Plan.

5. National and Regional Perspectives

Oral health has become a major topic on the national health agenda. Because much oral disease is preventable, it has been the focus of numerous studies and publications over the past several years. As its relationship to overall health has been more widely acknowledged, oral health has emerged as a priority public health concern.

Surgeon General's Report

Published in 2000, *Oral Health in America: A Report of the Surgeon General,* was notable for a number of reasons, but principal among them was the strong statement correlating oral health to general health. The report examined oral health status across the nation, evaluated how oral health can be promoted and maintained, and also identified opportunities for action designed to enhance oral health.

The Surgeon General's report detailed major findings which will have bearing on national, regional and local initiatives to address oral health:

- Oral diseases and disorders in and of themselves affect health and well-being throughout life.
- Safe and effective measures exist to prevent the most common dental diseases – dental caries and periodontal diseases.
- Lifestyle behaviors that affect general health such as tobacco use, excessive alcohol use, and poor dietary choices affect oral and craniofacial health as well.
- There are profound and consequential oral health disparities within the US population.
- More information is needed to improve America's oral health and eliminate health disparities.
- The mouth reflects general health and well-being.
- Oral diseases and conditions are associated with other health problems.
- Scientific research is key to further reduction in the burden of diseases and disorders that affect the face, mouth, and teeth.

Additionally, the Surgeon General's report creates a "framework for action" that will serve as the framework for New Hampshire's Oral Health Plan. The principles articulated in that report are:

- Change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health.
- Accelerate the building of the science and evidence base and apply science effectively to improve oral health.
- Build an effective health infrastructure that meets the oral health needs of all Americans and integrates oral health effectively into overall health.
- Remove known barriers between people and oral health services.
- Use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.[2]

2. US Department of Health and Human Services. *Oral Health In America: A Report of the Surgeon General.* Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

Recommendations of the Surgeon General's Workshop

Prior to release of the Surgeon General's Report, nearly 100 invitees representing dentistry and dental hygiene, medicine and nursing, law and government, business and industry, child and family advocacy, special needs populations, academe, communications, and foundations convened to consider disparities in oral health and dental care for America's children. Participants considered six approaches to these problems including:

1. increasing public awareness in order to promote public policy changes and impact individual behaviors;
2. promoting development and application of science and evidence-based care to enhance both consumer and practitioner behaviors;
3. integrating service delivery in order to meet the comprehensive health promotion and treatment needs of US children;
4. involving a range of health workers who come into contact with vulnerable children and their families in promoting oral health and dental care;
5. promoting public policies that lead to programmatic and funding support for oral health interventions; and
6. maximizing the role of public and private dental delivery systems to encourage positive oral health behaviors and provide essential services to all children.[3]

Eight major sets of recommendations emerging from the deliberations were presented at the June 2000 Surgeon General's Conference entitled, *The Face of a Child:*[4]

1. **Start early and involve all:** This set of recommendations includes establishing a dental home at age one; identifying high risk children early and promoting individualized preventive regimens in both medical and dental practice; developing community-based health coordinators to promote ongoing integration of oral health with general health care; developing day-care accreditation standards on oral health; and addressing the oral health needs of caregivers in order to promote more widespread attention to oral health.
2. **Assure competencies:** Recommendations include developing common core curricula for all health professionals on oral health that is comprehensive and integrative; and developing accreditation standards, guidelines, and performance measures that assure the inclusion of oral health promotion and, where appropriate, treatment in professional training and practice.
3. **Be accountable:** Recommendations include promoting school-based prevention, education, screening and referral programs on oral health; and developing performance measures and tracking systems to ensure that these programs are effectively implemented.
4. **Take public action:** Recommendations include developing activist coalitions that ensure stable-funded, community-based comprehensive health promotion and disease prevention; and crafting messages that specifically target providers, policymakers, and the public.
5. **Maximize the utility of science:** Recommendations include expanding the range and utility of science-based interventions; developing an evidence base on the effectiveness of oral disease management techniques; and developing a coordinated agenda across basic, applied, and health services research to promote oral health and effective dental care.

3. Edelstein B.L. "Forward to the Background Papers from the US Surgeon General's Workshop on Children and Oral Health." *Ambulatory Pediatrics,* 2(2 Supplement) 2002.

4. *The Face of a Child: Surgeon General's Conference on Children and Oral Health,* June 12-13, 2000, Washington, DC Conference agenda, abstracts and proceedings available at www.nidcr.nih.gov/sgr/children/children.htm

6. **Fix public programs:** Recommendations include demonstrating cost-benefits of prevention and disease management; overhauling Medicaid EPSDT dental programs; encouraging provider participation in Medicaid through various incentives; and enhancing the strength and viability of the dental safety net.
7. **Grow an adequate workforce:** Recommendations promote prioritizing community-based educational experiences for dentists and hygienists in training; expanding the numbers of pediatric and public health dentists; engaging allied personnel more effectively especially in health promotion and disease prevention; and encouraging an expanded number of minority providers in the dental professions.
8. **Empower families and enhance their capacities:** Recommendations include media and key-contact campaigns to translate oral health needs into demands for dental educational and treatment services; and using risk-based methods to tailor care to the individual needs of children and their families while respecting family and cultural determinants of health and health behaviors.

While these recommendations focused particularly on children, they are useful strategies for addressing almost all under-served populations.

Healthy People 2010

Published by the Office of Disease Prevention and Health Promotion, US DHHS, *Healthy People 2010* is the "prevention agenda" for the nation. It includes a comprehensive set of disease prevention and health promotion objectives for the US, designed to identify and reduce preventable threats to health and identifies two broad goals for achievement by 2010:

1. Increase quality and years of health life; help individuals of all ages increase life expectancy and improve quality of life.
2. Eliminate health disparities among all segments of the population.[5]

Healthy People 2010 includes oral health among its principal areas of focus, and sets the following as its goal: Prevent and control oral and craniofacial diseases, conditions and injuries and improve access to related services. Additionally, the document details a number of objectives specific to oral health, in areas such as dental caries experience and untreated tooth decay; tooth loss; periodontal diseases; sealants; fluoridation; school-based services; health centers with oral health services; and use of the oral health care system.

Summary of National Surveys

Healthy People 2010 data are derived from a number of national surveys fielded by various US Department of Health and Human Services agencies. These include Head Start surveys, National Health Interview Surveys, Medical Expenditure Panel Surveys, and National Health and Nutrition Examination Surveys among others. Taken together they tell a story of mixed oral health and profound disparities in oral health and access to dental care for children, adults, and those with special health care needs.

In summarizing oral health findings, the *Healthy People 2010* document reports that the oral health of US citizens is still of concern and that oral health varies widely by socioeconomic status

5. US Department of Health and Human Services. *Healthy People 2010.* Washington, DC: US Department of Health and Human Services, Office of Disease Prevention and Health Promotion.

and general health condition. For example, 39% of people aged 65 or older with only a high school education are missing all of their teeth while only 13% of people with some college education are edentulous. National surveys reveal that the three primary diseases of the mouth – tooth decay, periodontal disease, and oral/pharyngeal cancer – remain too common, especially given that all are amenable to prevention.[6]

Tooth decay continues to be the single most common chronic disease of childhood with nearly one in five preschoolers, one in two second graders and three in four adolescents experiencing tooth decay. Caries continues into adulthood with one in three US adults reportedly having untreated tooth decay. Unmet need for dental care has been reported for children with the finding that 73% of all children with one or more unmet health care needs has a parentally reported unmet need for dental care – three times greater than unmet needs for medical care. Nationally, among children covered by Medicaid, only one in four obtains a dental service in a year. This is a particularly significant finding because young children living in poor families (including those eligible for Medicaid) are nearly twice as likely to have tooth decay, have twice as many cavities when they do, and experience pain twice as often as children living in affluent families (>400% of poverty). Children of color are also more likely to experience tooth decay and are generally less likely to receive dental services.

Periodontal (gum) disease is highly prevalent and is increasingly recognized to impact significantly and negatively on general health. *Healthy People 2010* reports that one in five adults has destructive periodontal disease – disease that frequently leads to tooth loss.

National surveys show that "some 31,000 new cases of oral and pharyngeal cancer were expected to be diagnosed in 1999, and approximately 8,100 persons were expected to die from the disease. Oral and pharyngeal cancer occurs more frequently than leukemia, Hodgkin's disease, and cancers of the brain, cervix, ovary, liver, pancreas, bone, thyroid gland, testes, and stomach. Oral and pharyngeal cancer is the 7th most common cancer found among white males (4th most common among black men) and the 14th most common among US women. The 5-year survival rate for oral and pharyngeal cancer is only 52 percent and most of these cancers are diagnosed at late stages."[7]

Federal and private surveys of dental insurance coverage reveal that having dental insurance is strongly associated with having more dental care – even for high-income individuals and families. Yet two and a half times more children are without dental coverage than medical coverage and over 100 million Americans have no dental coverage at all. Similarly expenditures on dental care vary significantly by family income. Not surprisingly, low income families expend disproportionately more of their income on dental care than higher income families.

Taken all together, these national studies reflect observations in New Hampshire that oral health continues to be problematic for many and that the benefits of good oral health are not uniformly enjoyed by all of its citizens.

Significant Legislative Initiatives

Recent years have seen significant federal and state legislation related to oral health and access to dental care – legislation that may help shape and inform initiatives undertaken in response to this plan. Additionally, a variety of public-private partnerships (including this one) are underway and national organizations of state policymakers have increasingly attended to this issue. Among organi-

6. *Healthy People 2010* Chapter 21 Oral Health op cit.

7. Edelstein B.L. "Disparities in Oral Health and Access to Care: Findings of National Surveys." *Ambulatory Pediatrics,* 2(2 Supplement) 2002.

zations involved in this process are the National Governors Association, the Conference of State Legislatures, the Association of State and Territorial Health Officers, and the Association of Maternal and Child Health Programs. Many recent advances, however, have been dampened significantly by the current economic downturn with its stringent demands on state budgets.

President Bush signed the Safety Net Amendments Act in January 2003 which includes authorization for matching grants to states (states must contribute 40% in cash or in-kind sources to access one million dollars in federal grants) to improve dental access, particularly in rural areas. In 2000, the Child Health Act authorized grants to states to address novel preventive strategies around early childhood tooth decay. Neither of these federal programs has yet been funded in the current budget process.

When last considered by Congress, the Health Professions Training program was expanded to include funds to train not only advanced-practice general dentists and public health dentists but also pediatric dentists. This has resulted in a nearly 10% increase in the number of children's dentists being trained. Current lobbying efforts seek to expand another federal training program for pediatric dentists from training 9 dentists per year to 60 per year. Also under consideration is the Children's Dental Health Act which would provide additional grants to states to improve dental access for children. Similarly, the recently enacted Children's Hospital Graduate Medical Education program allows for training additional pediatric dentists in specialty hospitals.

More ominous for ensuring access to care are recent state changes in Medicaid programs. As of March 2003 only 14 states continue to provide reasonably comprehensive dental benefits to poor adults through Medicaid. More than half of the states, including New Hampshire, provide only minimal care for relief of pain and infection or no dental care at all. The trend toward erosion of dental benefits is beginning to impact children as well. Increasing numbers of states are cutting dental benefits in their state child health insurance plans and the Administration has recently advanced two programs that would allow reduction in dental coverage for poor children in Medicaid.

Among state-level initiatives of note are efforts to extend the roles of dental hygienists and dental assistants, to increase community water fluoridation, to engage medical providers in oral health promotion, to license foreign dental school graduates, to encourage post-doctoral dental training, to expand the availability of sealants, and to provide incentives to encourage dentists to practice in geographically underserved areas.

Healthy New Hampshire 2010

Using the national *Healthy People 2010* framework, *Healthy New Hampshire 2010* is the state's agenda for health promotion and disease prevention for the first decade of the 21st century. Developed collaboratively by the Healthy New Hampshire 2010 Leadership Council and the New Hampshire Department of Health and Human Services, "it represents a shared vision and acknowledges a shared responsibility for improving the health and quality of life for all New Hampshire citizens."[8] With regard to oral health, this document identifies barriers to good oral health. These include cost of care, lack of dental insurance, lack of public programs, a shortage of dentists and dental hygienists, language and cultural barriers, and fear of dental visits. It also sets as its objectives an increase in the percentage of third grade children with dental sealants on their teeth and an increase in the percentage of New Hampshire residents served by a fluoridated public water supply.

8. New Hampshire Department of Health and Human Services. *Healthy New Hampshire 2010*. Concord, NH, 2001.

Vision and Recommendations: A Framework for Actions

Throughout the planning process, the Coalition for New Hampshire Oral Health Action operated with a set of underlying premises regarding the promotion of oral health and the provision of dental care: While health and health care are ultimately family and community considerations and New Hampshire's regions and communities have unique capacities and constraints, state level activity can support communities in improving oral health and dental care. It was determined that the resulting plan, therefore, should not only identify a "standard" level of oral health for all residents, but should articulate priorities for both statewide and community-level action; identify tools and resources to address oral health needs; coordinate and support existing community-based systems; and empower individuals to access and utilize available resources.

It was acknowledged by the Coalition that while there are common underlying issues and problems across New Hampshire, variation exists from region to region, community to community – in terms of unique needs, available resources and competencies. This means that there is the need to identify statewide initiatives that will have the capacity to benefit all communities – such as improving Medicaid reimbursement and establishing funding mechanisms for local system development – knowing that these initiatives may create different outcomes community by community.

This plan establishes a vision and model for a community-based integrated oral health system, which is designed to improve oral health and dental care for New Hampshire residents by emphasizing where needs are unmet and care inaccessible, and prioritizing resource distribution to address those issues. This community-based model implies that local systems will be built around functional geographical areas, and will be both internally and externally accountable. It will also require collaboration and communication among community-based systems to ensure that the future is informed and shaped by both successes and failures. The model envisions an on-going role for the Coalition for New Hampshire Oral Health Action to advocate for and initiate state-level action and monitor and support community-level implementation.

It is not the intent of this report to provide a comprehensive review of the oral health status of New Hampshire's residents, nor a restatement of the scope of the problem. Instead, on the following pages, the Coalition for New Hampshire Oral Health Action offers a vision and discussion of what actions will be necessary to bring oral health and its positive impact on well-being, to the residents of New Hampshire. That there are disparities in the oral health status of New Hampshire residents is undisputed. Finding ways to reduce those disparities is the subject of this report.

The goals and objectives identified by the Coalition have been presented in the framework outlined in the Surgeon General's Report, *Oral Health in America,* and are organized under the principal components identified in that document. This plan is intended to be a "living document" and, as such, will be revised from time to time as necessary and appropriate. Initial responsibilities for the implementation of primary objectives have been assigned. Further responsibilities and timelines will be developed as the implementation process begins.

Vision

Residents of New Hampshire will have the opportunity to achieve and maintain oral health through access to an effective system of health services which promotes appropriate health behaviors.

These services, which include assessment, prevention, health promotion, education, counseling, and treatment, will be provided through an integrated system of health care that assures accessibility, affordability, high quality, appropriateness to individuals' needs, and responsiveness to individuals' circumstances.

Recommendations

Principle

I. Change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health.

Goal

I.A. Increase public perception of the importance of good oral health as a component of overall health.

Objective

I.A.1. Develop a statewide oral health awareness and education campaign.

Strategies

I.A.1.a. Develop a public education campaign.

I.A.1.b. Develop a strong advocacy campaign for elected officials, government, private sector leaders and charitable foundations, to create public policy for improving oral health.

Objective

I.A.2. Integrate oral health with general medical care.

Strategies

I.A.2.a. Provide educational guidelines for the prevention, identification and treatment of oral diseases to primary medical care providers.

I.A.2.b. Provide oral assessment, health promotion and referrals as necessary to patients in all primary care settings.

I.A.2.c. Support recommendations that by the age of one year, all children receive an oral assessment, and referral to a dentist as necessary.

I.A.2.d. Engage and empower families in establishing basic oral health, from the prenatal period on.

I.A.2.d.(i). Utilize existing programs such as Home Visiting NH and Parents as Teachers to reinforce principles of good oral health.

I.A.2.e. Include oral health objectives in all published health promotion and prevention protocols and guidelines.

Objective

I.A.3. Integrate comprehensive oral health curricula in general health curricula and promote in all New Hampshire schools.

Strategies

I.A.3.a. Complete the development of oral health curricula for all grades.

I.A.3.a.(i). Maintain and update oral health curricula as necessary.

I.A.3.b. Coordinate efforts among the Department of Education, oral health providers, school administration, school nurses and school health educators to promote appropriate implementation of curricula.

I.A.3.c. Work toward the elimination of unhealthy snacks and drinks from school vending machines.

I.A.3.c.(i). Promote the use of the Task Force of NH Health Professionals for Healthy School Nutrition Tool Kit.

Principle

II. Apply science effectively to improve oral health.

Goal

II.A. Assess the oral health status of New Hampshire residents.

Objective

II.A.1. Develop and maintain a comprehensive epidemiological oral health surveillance system to identify, investigate and monitor oral health and oral health services.

Strategies

II.A.1.a. Identify critical data elements and standards needed for effective planning and program development.

II.A.1.b. Continue school-based oral health surveys every three years to assess trends in the oral health status of children enrolled in New Hampshire schools.

II.A.1.c. Develop data collection and analysis capacities at the local level through training and technical support.

Goal

II.B. Reduce the burden and progression of oral diseases in New Hampshire by integrating best available science and evidence-based treatment into clinical practice and policy.

Objective

II.B.1. Access and disseminate leading edge information on oral health science.

Strategy

II.B.1.a. Establish and maintain linkages with selected regional dental schools, research institutes and oral health policy centers.

Goal

II.C. Reduce the incidence of dental caries through evidence-based public health interventions.

Objective

II.C.1. Maximize the benefits of fluoride in preventing and controlling dental caries.

Strategies

II.C.1.a. Develop a statewide community action campaign to achieve fluoridation of public water supplies.

II.C.1.b. Simplify the process for prescribing and using systemic and topical fluoride by primary care physicians.

II.C.1.b.(i). Simplify access to and reporting of well water testing for fluoride.

Objective

II.C.2. Implement and maintain the capacity for a statewide school-based sealant program.

Strategies

II.C.2.a. Create the capacity for a universal school-based sealant program.

II.C.2.a.(i). Engage hygienists, dental assistants and volunteer dentists to implement school-based sealant program.

Goal

II.D. Increase early detection and reduce the incidence of oral and pharyngeal cancers.

Objective

II.D.1. Support efforts to reduce tobacco and alcohol use among New Hampshire residents.

Strategies

II.D.1.a. Increase awareness of the link between tobacco and alcohol use and oral and pharyngeal cancers.

II.D.1.b. Coordinate efforts among oral health providers, school administration, school nurses, school health educators, alcohol and tobacco prevention task forces, etc., to implement comprehensive educational programs regarding the dangers of tobacco and alcohol use.

II.D.1.c. Educate primary care providers regarding the importance of early detection and treatment of oral and pharyngeal cancers.

II.D.1.d. Enlist oral health and primary care providers to participate in alcohol and tobacco education and cessation programs.

II.D.1.d.(i). Provide continuing education to oral health and primary care providers regarding effective approaches to reduce the use of alcohol and tobacco.

Goal

II.E. Reduce the incidence of oral and facial injuries.

Objective

II.E.1. Recommend the requirement of the use of face-masks and mouthguards in all school and other sports programs.

Strategy

II.E.1.a. Coordinate efforts among school personnel, coaches, and recreation programs regarding the importance of injury prevention.

Principle

III. Build an effective health infrastructure that meets the oral health needs of all and integrates oral health effectively into overall health.

Goal

III.A. Enhance the existing workforce to meet the diverse oral health needs of all New Hampshire residents.

Objective

III.A.1. Maximize the capacity of the oral health workforce to address the needs of the population.

Strategies

III.A.1.a. Establish a task force comprised of appropriate leaders and policymakers to monitor and address the changing needs of the population.

III.A.1.a.(i). Conduct periodic evaluations of the workforce model, and refine as necessary to address the evolving needs and demands of the population.

III.A.1.a.(ii). Develop flexibility in workforce policies to assure that population needs can be met in a timely and effective manner.

III.A.1.b. Develop and promote career counseling at all New Hampshire high schools to encourage students to pursue careers in oral health.

III.A.1.c. Recruit more dentists, especially those who see high risk and vulnerable populations such as the economically disadvantaged, young children, the elderly, the developmentally disabled, and those with HIV/AIDS, to offset a provider shortage in New Hampshire.

III.A.1.c.(i). Pursue the potential to fund positions for New Hampshire students at New England dental schools.

III.A.1.c.(ii). Continue to provide loan repayment to dentists willing to serve New Hampshire's indigent and high risk populations.

III.A.1.d. Pursue the use of dental externs and residents by establishing training programs at safety net facilities.

III.A.1.e. Expand the number of dental hygienists in New Hampshire working in both public health and private office settings.

III.A.1.e.(i). Expand the facilities and training program for dental hygienists at the New Hampshire Technical Institute, and maximize their use.

III.A.1.e.(i).(a). Create a partnership with the New Hampshire Dental Society to fund the training program.

III.A.1.e.(ii). Recruit more dental hygienists to New Hampshire.

III.A.1.e.(ii).(a). Pursue state and private foundation support for recruitment and training of public health hygienists.

III.A.1.f. Pursue the use of new dental and non-dental providers to enhance the oral health workforce.

III.A.1.f.(i). Create the capacity to use expanded function dental assistants (EFDA) in dental practices and safety net facilities to improve productivity.

III.A.1.f.(ii). Use primary medical care practitioners to provide oral assessment and preventive services.

III.A.1.f.(ii).(a). Establish training and protocols for basic oral examination for primary care medical providers.

III.A.1.f.(iii). Build the capability among prenatal care providers to provide patients with oral assessment, education and appropriate referral for oral health services.

III.A.1.f.(iv). Develop a new professional category of Oral Health Educator.

Objective

III.A.2. Integrate, improve, expand and sustain the oral health component of the healthcare safety net.

Strategies

III.A.2.a. Advocate for funding for those organizations that provide oral health services to high risk and underserved populations from New Hampshire's public and private funders.

III.A.2.b. Pursue federal and private foundation funding to augment state-funded oral health initiatives.

III.A.2.c. Encourage all community health centers to provide oral health services.

III.A.2.d. Encourage private dentists and hygienists to provide services within the safety net.

III.A.2.e. Utilize the state loan repayment program for dentists and hygienists who agree to practice in underserved areas.

III.A.2.f. Encourage New Hampshire hospitals to play a major role in supporting the safety net.

III.A.2.f.(i). Advocate that all New Hampshire hospitals participate in establishing, financing and maintaining safety net oral health services in their communities.

III.A.2.f.(ii). Encourage New Hampshire hospitals to prioritize oral health services in the allocation of community benefit dollars.

III.A.2.f.(iii). Advocate that all New Hampshire hospitals develop and maintain a dental on-call system through their Emergency Departments.

Principle

IV. Remove known barriers between people and oral health services.

Goal

IV.A. Eliminate barriers and enhance access to good oral health.

Objective

IV.A.1 Create system-level improvements to treat high risk populations such as children, the elderly, uninsured adults, the developmentally disabled, the mentally ill and those with HIV/AIDS.

Strategies

IV.A.1.a. Increase the capacity of the Medicaid program.

IV.A.1.a.(i). Reinstitute the managed care option to NH Medicaid.

IV.A.1.a.(ii). Streamline procedures for dental provider participation in Medicaid.

IV.A.1.b. Pursue an increase in Medicaid reimbursement rates for dental and hygiene services to encourage more provider participation in the Medicaid program.

IV.A.1.c. Establish coding for Medicaid reimbursement for primary care providers to deliver oral health procedural services.

Objective

IV.A.2. Enhance the competency of the oral health workforce to treat high risk populations.

Strategies

IV.A.2.a. Develop dental residency programs within programs that focus on high risk populations.

IV.A.2.b. Develop continuing education programs for the oral health workforce that focus on the unique issues of treating high risk populations.

Objective

IV.A.3. Build a care coordination and case management system especially for those at high risk.

Strategies

IV.A.3.a. Implement a care coordination model that uses education and prevention to improve oral health.

IV.A.3.a.(i). Provide a link between individuals and all service providers.

IV.A.3.a.(ii). Reimburse for care coordination.

IV.A.3.b. Provide oral health services at sites used by high risk populations, such as adult/child day care centers.

Objective

IV.A.4. Improve access to dental insurance among all sectors of the population.

Strategies

IV.A.4.a. Encourage New Hampshire employers to offer dental insurance.

IV.A.4.a.(i). Increase the awareness among New Hampshire business and industry of the importance of good oral health to productivity.

IV.A.4.b. Maintain and increase participation in current programs such as Healthy Kids Gold and Healthy Kids Silver, and reinstate NEDD Kids.

IV.A.4.c. Maintain and expand Medicaid to cover non-emergent oral health services for adults.

Principle

V. Use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.

Goal

V.A. Further integrate the efforts between the public and private sectors to address the oral health needs of the residents of New Hampshire.

Objective

V.A.1. Create a statewide clearinghouse to serve as a resource for information on existing oral health programs, technical support, funding consultation and successful public health models.

Strategies

V.A.1.a. Conduct a baseline assessment of all current models of oral health service delivery.

V.A.1.b. Establish best practices for oral health service delivery.

V.A.1.c. Develop a toolbox for building community collaboratives for oral health service delivery.

Objective

V.A.2. Promote regional and community-based collaborative efforts among agencies, organizations and individuals to address oral health needs.

Strategies

V.A.2.a. Establish funding priorities that require collaboration and coordination within communities.

V.A.2.b. Develop and maintain linkages to local and regional business/industry groups.

Objective

V.A.3. Monitor the implementation of the New Hampshire Oral Health Plan.

Strategies

V.A.3.a. Convene and maintain a subgroup of the Coalition to oversee the monitoring of implementation of the New Hampshire Oral Health Plan.

V.A.3.b. Identify funding sources to assure ongoing support for implementation activities.

Objective

V.A.4. Review and revise the New Hampshire Oral Health Plan as necessary.

Appendices

Appendix 1.
Commitment to the Implementation of the Oral Health Plan

The following letter of commitment will be signed by all Coalition members.

The Coalition for New Hampshire Oral Health Action has worked collaboratively on the development of the New Hampshire Oral Health Plan: A Framework for Action, a plan for improving the oral health of New Hampshire Residents.

Implementation of the plan will require continued management and collaboration among the stakeholders. To ensure that the work of the Coalition moves forward to achieve its goals and objectives, the members hereby affirm that they will agree to use best efforts to:

1. Promote and participate in the implementation of the Framework for Action.
2. Serve as liaison to inform their organizations and constituencies about Coalition initiatives.
3. Agree to report periodically to the Coalition on the progress toward achieving those recommendations in the Plan relevant to their organizations and constituencies.
4. To continue as a member of the Coalition.
5. To consider an investment in the sustainability of the Coalition and the implementation of the Framework for Action.

Name: _____

Organization: _____

Date: _____

Signature: _____

Appendix 2.
Executive Summary, Oral Health in America: A Report of the Surgeon General

A Framework for Action

All Americans can benefit from the development of a National Oral Health Plan to improve quality of life and eliminate health disparities by facilitating collaborations among individuals, health care providers, communities, and policymakers at all levels of society and by taking advantage of existing initiatives. Everyone has a role in improving and promoting oral health. Together we can work to broaden public understanding of the importance of oral health and its relevance to general health and well-being, and to ensure that existing and future preventive, diagnostic, and treatment measures for oral diseases and disorders are made available to all Americans. The following are the principal components of the plan:

Change perceptions regarding oral health and disease so that oral health becomes an accepted component of general health.

- Change public perceptions. Many people consider oral signs and symptoms to be less important than indications of general illness. As a result, they may avoid or postpone needed care, thus exacerbating the problem. If we are to increase the nation's capacity to improve oral health and reduce health disparities, we need to enhance the public's understanding of the meaning of oral health and the relationship of the mouth to the rest of the body. These messages should take into account the multiple languages and cultural traditions that characterize America's diversity.
- Change policymakers' perceptions. Informed policymakers at the local, state, and federal levels are critical in ensuring the inclusion of oral health services in health promotion and disease prevention programs, care delivery systems, and reimbursement schedules. Raising awareness of oral health among legislators and public officials at all levels of government is essential to creating effective public policy to improve America's oral health. Every conceivable avenue should be used to inform policymakers – informally through their organizations and affiliations and formally through their governmental offices – if rational oral health policy is to be formulated and effective programs implemented.
- Change health providers' perceptions. Too little time is devoted to oral health and disease topics in the education of nondental health professionals. Yet all care providers can and should contribute to enhancing oral health. This can be accomplished in several ways, such as including an oral examination as part of a general medical examination, advising patients in matters of diet and tobacco cessation, and referring patients to oral health practitioners for care prior to medical or surgical treatments that can damage oral tissues, such as cancer chemotherapy or radiation to the head and neck. Health care providers should be ready, willing, and able to work in collaboration to provide optimal health care for their patients. Having informed health care professionals will ensure that the public using the health care system will benefit from interdisciplinary services and comprehensive care. To prepare providers for such a role will involve, among other factors, curriculum changes and multidisciplinary training.

Accelerate the building of the science and evidence base and apply science effectively to improve oral health.

Basic behavioral and biomedical research, clinical trials, and population-based research have been at the heart of scientific advances over the past decades. The nation's continued investment in research is critical for the provision of new knowledge about oral and general health and disease for years to come and needs to be accelerated if further improvements are to be made. Equally important is the effective transfer of research findings to the public and health professions.

However, the next steps are more complicated. The challenge is to understand complex diseases caused by the interaction of multiple genes with environmental and behavioral variables – a description that applies to most oral diseases and disorders – and translate research findings into health care practice and healthy lifestyles.

This report highlights many areas of research opportunities and needs in each chapter. At present, there is an overall need for behavioral and clinical research, clinical trials, health services research, and community-based demonstration research. Also, development of risk assessment procedures for individuals and communities and of diagnostic markers to indicate whether an individual is more or less susceptible to a given disease can provide the basis for formulating risk profiles and tailoring treatment and program options accordingly.

Vital to progress in this area is a better understanding of the etiology and distribution of disease. But as this report makes clear, epidemiologic and surveillance databases for oral health and disease, health services, utilization of care, and expenditures are limited or lacking at the national, state, and local levels. Such data are essential in conducting health services research, generating research hypotheses, planning and evaluating programs, and identifying emerging public health problems. Future data collection must address differences among the subpopulations making up racial and ethnic groups. More attention must also be paid to demographic variables such as age, sex, sexual orientation, and socioeconomic factors in determining health status. Clearly, the more detailed information that is available, the better can program planners establish priorities and targeted interventions.

Progress in elucidating the relationships between chronic oral inflammatory infections, such as periodontitis, and diabetes and glycemic control as well as other systemic conditions will require a similar intensified commitment to research. Rapid progress can also occur with efforts in the area of the natural repair and regeneration of oral tissues and organs. Improvements in oral health depend on multidisciplinary and interdisciplinary approaches to biomedical and behavioral research, including partnerships among researchers in the life and physical sciences, and on the ability of practitioners and the public to apply research findings effectively.

Build an effective health infrastructure that meets the oral health needs of all Americans and integrates oral health effectively into overall health.

The public health capacity for addressing oral health is dilute and not integrated with other public health programs. Although the *Healthy People 2010* objectives provide a blueprint for outcome measures, a national public health plan for oral health does not exist. Furthermore, local, state, and federal resources are limited in the personnel, equipment, and facilities available to support oral health programs. There is also a lack of available trained public health practitioners knowledgeable about oral health. As a result, existing disease prevention programs are not being implemented in many communities, creating gaps in prevention and care that affect the nation's neediest populations. Indeed, cutbacks in many state budgets have reduced staffing of state and territorial dental programs and curtailed oral health promotion and disease prevention efforts. An enhanced public health infrastructure would facilitate the development of strengthened partnerships with private practitioners, other public programs, and voluntary groups.

There is a lack of racial and ethnic diversity in the oral health workforce. Efforts to recruit members of minority groups to positions in health education, research, and practice in numbers that at least match their representation in the general population not only would enrich the talent pool, but also might result in a more equitable geographic distribution of care providers. The effect of that change could well enhance access and utilization of oral health care by racial and ethnic minorities.

A closer look at trends in the workforce discloses a worrisome shortfall in the numbers of men and women choosing careers in oral health education and research. Government and private sector leaders are aware of the problem and are discussing ways to increase and diversify the talent pool, including easing the financial burden of professional education, but additional incentives may be necessary.

Remove known barriers between people and oral health services.

This report presents data on access, utilization, financing, and reimbursement of oral health care; provides additional data on the extent of the barriers; and points to the need for public-private partnerships in seeking solutions. The data indicate that lack of dental insurance, private or public, is one of several impediments to obtaining oral health care and accounts in part for the generally poorer oral health of those who live at or near the poverty line, lack health insurance, or lose their insurance upon retirement. The level of reimbursement for services also has been reported to be a problem and a disincentive to the participation of providers in certain public programs. Professional organizations and government agencies are cognizant of these problems and are exploring solutions that merit evaluation. Particular concern has been expressed about the nation's children, and initiatives such as the State Children's Health Insurance Program, while not mandating coverage for oral health services, are a positive step. In addition, individuals whose health is physically, mentally, and emotionally compromised need comprehensive integrated care.

Use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.

The collective and complementary talents of public health agencies, private industry, social services organizations, educators, health care providers, researchers, the media, community leaders, voluntary health organizations and consumer groups, and concerned citizens are vital if America is not just to reduce, but to eliminate, health disparities. This report highlights variations in oral and general health within and across all population groups. Increased public-private partnerships are needed to educate the public, to educate health professionals, to conduct research, and to provide health care services and programs. These partnerships can build and strengthen cross-disciplinary, culturally competent, community-based, and community-wide efforts and demonstration programs to expand initiatives for health promotion and disease prevention. Examples of such efforts include programs to prevent tobacco use, promote better dietary choices, and encourage the use of protective gear to prevent sports injuries. In this way, partnerships uniting sports organizations, schools, churches, and other community groups and leaders, working in concert with the health community, can contribute to improved oral and general health.

Conclusion

The past half century has seen the meaning of oral health evolve from a narrow focus on teeth and gingiva to the recognition that the mouth is the center of vital tissues and functions that are critical to total health and well-being across the life span. The mouth as a mirror of health or disease, as a sentinel or early warning system, as an accessible model for the study of other tissues and organs, and as a potential source of pathology affecting other systems and organs has been described in earlier chapters and provides the impetus for extensive future research. Past discoveries have enabled Americans today to enjoy far better oral health than their forebears a century ago. But the evidence that not all Americans have achieved the same level of oral health and well-being stands as a major challenge, one that demands the best efforts of public and private agencies and individuals.

Appendix 3.

Dental and Medical Primary Care Workforce and Education Data

Prepared by David M. Krol, M.D.

Contents

DENTISTS

Table 1: Number of Dentists 1998-2008 (projected)

Reflecting national trends, the number of dentists serving New England's population is reasonably stable. Recent years have seen significant increases (~25% from 1998-2001), perhaps reflecting Boston dental school graduates' movement outward from the more dentist-congested population rings surrounding the core metropolitan area and growth of New Hampshire's southern population. Federal health professional workforce projections out to 2008 suggest a decline in absolute numbers of New Hampshire dentists of ~8% between 2001 and 2008, even as the state's population is anticipated to increase.

Number of Dentists 1998 - 2008 (projected)

	1998	2000	2001	2008
Connecticut	3,400	2,981	2,669	3,750
Maine	600	584	608	700
Massachusetts	4,250	NA	4,500	4,850
New Hampshire	**700**	**825**	**868**	**800**
Rhode Island	750	NA	719	800
Vermont	300	350	347	300

Source: State occupational projections: 1998-2008; http://dws.state.ut.us/occ/projections.asp Accessed March 5, 2002.

Table 2: Ratio of Dentists per 100,000 population 1998

New England enjoys a dentist-to-population ratio that is nearly 9% higher than the US average but shows wide variation between states — from Maine with the fewest to Connecticut with the most. New Hampshire's dentist-to-population ratio ranks third lowest for New England. It's dentist availability is 6.4% higher than the US average but 5% lower than the NE average. These findings are not adjusted for age which may be a significant factor, given the overall "graying" of US dentists and the migration of younger professionals to western states where population growth is most dramatic.

Ratio of Dentists per 100,000 Population 1998

	Dentists/1000 population 1998	Rank Order
Connecticut	65.9	1
Maine	43.9	6
Massachusetts	61.6	2
New Hampshire	**51.5**	**4**
Rhode Island	50.1	5
Vermont	52.7	3
United States	48.4	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm

Table 3: Percent Change in Dentist Population per 100,000 population 1991-1998

Between 1991 and 1998 New Hampshire experienced a 9% decrease in the number of dentists for every 100,000 people compared to a national decline of 12% and New England average decline of 7%. At 9%, New Hampshire lost relatively more dentist workforce for its population than did Rhode Island, Maine, and Vermont.

Change in Dentists per 100,00 Population: 1991-1998

	Percent change 1991-1998	Rank Order
Connecticut	-11%	1
Maine	-3%	5
Massachusetts	-11%	2
New Hampshire	-9%	**3**
Rhode Island	-6%	4
Vermont	-2%	6
United States	-12%	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002.

Table 4: Percentage of Female Dentists 1998

In 1998 10.8% of the dentists in New Hampshire were women. This figure is less than the national average of 12.6%, but average for New England.

Over recent years, the percentage of new dentists who are women has steadily increased, raising questions regarding future dental workforce productivity as women elect to balance family and profession. Initial evidence about women's career patterns suggests that over a lifetime, female dentists are as productive as male dentists, but that their peak productivity tends to occur later in their practice careers.

Some suggest that women dentists may be more attuned to addressing the needs of the underserved – although there is no empirical evidence to support that belief at this time.

Percentage of Female Dentists 1998

	Percentage of female dentists 1998	Rank Order
Connecticut	10.8%	4
Maine	8.9%	6
Massachusetts	14.4%	1
New Hampshire	10.8%	**3**
Rhode Island	11.3%	2
Vermont	10.0%	5
United States	12.6%	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002.

Table 5: Dental Schools and Advanced Dental Education

Of New England's four dental schools, three are located in Boston (Boston University, Tufts University, Harvard University) and one is in Connecticut (University of Connecticut). Boston schools are private, while the University of Connecticut is publicly supported.

Dentistry does not require advanced training beyond dental school, although some elect advanced training in either general dentistry or one of the eight recognized dental sub specialties. Advanced dental education programs included in this table are General Practice Residencies (one- or two-year programs, typically in hospitals, that further the training of general dentists); Advanced Education Programs in General Dentistry (like General Practice Residencies, except typically based in dental schools); and Pediatric Dentistry training programs that prepare dentists as specialists in the care of children. Pediatric dentistry residencies are affiliated with each of the four dental schools identified here, and a new pediatric dentistry residency has been started (in 2002) at Yale University.

Dental Schools and Advanced Dental Education

	Number of Dental Schools and Advanced Training Programs	Rank Order
Connecticut	9	2
Maine	0	4
Massachusetts	14	1
New Hampshire	**1**	**3**
Rhode Island	1	3
Vermont	1	3

Source: Directory of ADEA Institutional Members and Association Officers 2001-2002. American Dental Education Association.

DENTAL HYGIENISTS

Table 6: Number of Hygienists 1998 -2008 (projected)

Federal dental workforce data suggests a reasonably steady supply of Registered Dental Hygienists between 1998 and 2001 with an anticipated major increase of 50.7% between 2001 and 2008.

Registered Dental Hygienists are licensed dental professionals who provide an array of preventive services including health education, prophylaxis, and fluoride treatments as well as additional preventive treatments as authorized by individual state statutes and regulations. Depending upon the state, hygienists may function under the "direct" or "indirect" supervision of a dentist or may function independently of dentists in specific sites or in all sites.

Services provided by hygienists represent one important component of comprehensive dental care. Unlike nurse practitioners in medicine, who provide a comprehensive range of services to their level of expertise, dental hygienists' purview is specifically related to preventive (rather than corrective) care.

Number of Hygienists 1998 - 2008 (projected)

	1998	2000	2001	2008
Connecticut	2,700	3,060	2,700	3,400
Maine	700	715	912	950
Massachusetts	4,750	5,596	6,600	7,050
New Hampshire	**1,000**	**900**	**995**	**1,500**
Rhode Island	750	NA	795	900
Vermont	550	450	450	750

Sources: Synopses of state dental public health programs, Centers for Disease Control, 2000; http://www2.cdc.gov/nccdphp/doh/synopses/index.asp Accessed February 20, 2002

State occupational projections: 1998-2008; http://almis.dws.state.ut.us/occ/projections.asp Accessed March 5, 2002.

Table 7: Ratio of Hygienists per 100,000 Population 1998

All New England states enjoy a hygienist-to-population ratio higher than the United States, with nearly 50% more hygienists to population than the United States average. New Hampshire ranks second only to Vermont among New England States and has a hygienist-to-population ratio that is 62% higher than the United States mean. These findings suggest a potentially greater availability of preventive services in New Hampshire than in most other states.

Ratio of Hygienists per 100,000 Population 1998

	Dental Hygienists/1000 Population 1998	Rank Order
Connecticut	81.9	3
Maine	56.1	6
Massachusetts	77.3	5
New Hampshire	**84.3**	**2**
Rhode Island	78.0	4
Vermont	89.7	1
United States	52.1	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002

Table 8: Percent Change in Ratio of Hygienist Graduates 1985-86 to 1995-96

This table anticipates future hygienist availability in New Hampshire and New England. Additional information is needed for the period after 1996 for workforce projection and planning purposes, especially to reconcile these numbers with federal estimates of the hygienist workforce in 2008.

Percent Change in Ratio of Hygienist Graduates per 100,000 population 1985-86 to 1995-96

	Percent change in hygienist graduates per 100,000 Population	Rank Order
Connecticut	-8%	4
Maine	-36%	1
Massachusetts	-8%	5
New Hampshire	**-17%**	**3**
Rhode Island	150%	6
Vermont	-28%	2
United States	9%	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002

Table 9: Dental Hygienists: Permitted Functions and Supervision Levels by State, 2001

KEY		
	P	Physical presence of dentist is required
	N	Physical presence of dentist is not required
	U	Physical presence not required. No prior authorization by dentist required but there may be requirement for type of cooperative arrangement with a dentist(s). Some states require experience or special education by RDH.
	/	Where two letters are present in a box the first indicates the supervision level in the private dental office and the second in a "safety-net" site.
	—	Service is not a permitted function of RDH

	Prophytaxis	X-Rays	Local Anesthesia	Topical Anesthesia	Fluoride	Pit/fissure Sealants
Connecticut	N/U	N/U	—	N/U	N/U	N/U
Maine	N	N	P	N	N	N
Massachusetts	N	N	—	N	N	N
New Hampshire	**N**	**N**	—	**N**	**N**	**N**
Rhode Island	N	N	—	N	N	N
Vermont	N	N	P	N	N	N

	Root Planing	Soft Tissue Cuettage	Administer N2O	Study Cast Impressions	Place Perio Dressings	Remove Perio Dressings
Connecticut	N/U	—	—	N/U	N/U	N/U
Maine	N	N	—	N	P	N
Massachusetts	N	N	—	N	N	N
New Hampshire	**N**	—	—	**N**	—	**N**
Rhode Island	N	—	—	P	P	P
Vermont	N	—	—	N	N	N

	Place Sutures	Remove Sutures	Apply Cavity-liners and bases	Place Temporary Restorations	Remove Temporary Restorations	Place Amalgam Restorations
Connecticut	—	N/U	—	—	—	—
Maine	—	N	—	N	—	—
Massachusetts	—	N	—	N	P	P
New Hampshire	—	**N**	—	—	—	—
Rhode Island	—	P	P	P	P	—
Vermont	—	N	—	N	N	—

	Carve Amalgam Restorations	Finish Amalgam Restorations	Polish Amalgam Restorations	Place and Finish-Composite Resin Silicate Restore
Connecticut	—	—	N/U	—
Maine	—	—	N	—
Massachusetts	—	—	N	—
New Hampshire	—	—	**N**	—
Rhode Island	—	—	P	—
Vermont	—	N	N	—

Source: American Dental Hygienist Association. ADHA practice act overview chart of permitted functions and supervision levels by state. 2002.

Table 10: Ratio of Hygienists to Dentists 1998

Because dental hygienists provide one significant set of services and because of state legal requirements, they are typically collocated with dentists. The hygienist to dentist ratio suggests the preventive services capacity of dental offices.

Ratio of Hygienists to Dentists 1998

	Dental Hygienists/ Dentist Ratio 1998	Rank Order
Connecticut	1.2	6
Maine	1.3	5
Massachusetts	1.3	4
New Hampshire	**1.6**	**3**
Rhode Island	1.6	2
Vermont	1.7	1
United States	1.1	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002

Table 11: Entry Level Hygienist Programs 2002

Dental Hygiene programs vary by type and size. Some are "entry level" associates degree or bachelor degree programs, some are bachelor degree completion programs, and a few provide a "masters" level education. The "masters" level programs are typically for those seeking careers in teaching or administration. This table shows the number of "entry level" programs (Associate and Bachelor Degree programs) available in New England.

Entry Level Hygienist Programs 2002

	Number of entry level dental hygiene programs 2002	Rank Order
Connecticut	3	2
Maine	2	3
Massachusetts	7	1
New Hampshire	**1**	**4**
Rhode Island	1	4
Vermont	1	4

Source: Degree Completion Dental Hygiene Programs, American Dental Hygienists Association, 2002; http://www.adha.org/careerinfo/degree.htm Accessed March 5, 2002.

DENTAL ASSISTANTS

Table 12: Number of Dental Assistants 1998 & 2008 (projected)

Dental assistants refer to "chairside" auxiliaries who provide direct procedural assistance to dentists through "four handed dentistry." Their training may be through a short-term community college or proprietary course or "on-the-job."

Various states have developed either legislative or regulatory criteria to expand dental assistant functions as "EFDAs," (Expanded Function Dental Assistants). These additional authorizations may be modest (typically exposure of dental radiographs/x-rays) or extensive (including placement of fillings into teeth prepared by the dentist.)

Typically, a dentist works with one chairside assistant when serving a patient and may engage multiple chairside assistants in order to facilitate efficiency within and between operatories.

Number of Dental Assistants 1998 and 2008 (projected)

	1998	2008 (projected)
Connecticut	2,900	3,650
Maine	1,100	1,550
Massachusetts	5,300	8,000
New Hampshire	**900**	**1,400**
Rhode Island	700	850
Vermont	550	800

Source: State occupational projections: 1998-2008; http://slmis.dws.state.ut.us/occ/projections.asp

Table 13: Ratio of Dental Assistants per 100,000 Population 1998

Ratio of Dental Assistants per 100,000 Population 1998

	Dental Assistants per 100,000 population 1998	Rank Order
Connecticut	88.3	2
Maine	87.4	3
Massachusetts	87.1	4
New Hampshire	**77.6**	**5**
Rhode Island	72.9	6
Vermont	96.5	1
United States	85.6	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002

Table 14: Ratio of Dental Assistants to Dentists 1998

Although the absolute differences between states are small, the impact of additional assistants on practice productivity can be significant, and New England generally falls below the national mean in dentist-to-assistant ratio. This may reflect the fact that many states outside of New England typically allow dental assistants to perform some functions of a dental hygienist (partial prophylaxis), whereas New England dentists employ more hygienists than do their colleagues in other parts of the country.

Ratio of Dental Assistants to Dentists 1998

	Dental Assistants/ Dentists 1998	Rank Order
Connecticut	1.3	6
Maine	2.0	1
Massachusetts	1.4	5
New Hampshire	**1.5**	**3**
Rhode Island	1.5	4
Vermont	1.8	2
United States	1.8	—

Source: State Health Workforce Profiles, National Center for Health Workforce Information and Analysis, 1998; http://bhpr.hrsa.gov/healthworkforce/profiles/default.htm Accessed February 20, 2002

Table 15: Dental Assistant Programs 2001

Not all dental assistants are trained in formal programs. However, formal programs tend to ensure comprehensive training and relieve the dentist of responsibilities for instructing new staff. EFDA authorizations typically require formal training.

Dental Assistant Programs 2001

	Number of dental assistant education programs, 2001	Rank Order
Connecticut	6	2
Maine	1	3
Massachusetts	7	1
New Hampshire	**1**	**3**
Rhode Island	1	3
Vermont	1	3

Source: Dental Assisting, Dental hygiene and Dental Laboratory Technology Education Programs, American Dental Association, 2001 http://www.ada.org/prof/ed/programs/dahlt/index.html Accessed March 5, 2002.

MEDICAL PERSONNEL

Table 16: Medical Personnel

Primary medical care providers can be engaged in oral health promotion and disease prevention - particularly for pediatric populations- since dental caries (tooth decay) is initiated in the early toddler years when young children are frequently seen by medical personnel. Availability of primary care medical personnel for children is shown in the following chart.

Medical Personnel

	Number of general pediatricians in direct patient care 1998	Number of FP/GP in direct patient care 1998	Number of child health/ pediatric nurse practitioners active licences 2000	Rank Order
Connecticut	688	514	NA	2
Maine	147	402	70	3
Massachusetts	1,366	977	NA	1
New Hampshire	**174**	**340**	**78**	**4**
Rhode Island	199	166	NA	5
Vermont	108	218	33	6

Sources: Cull, W.L.. Physician Workforce Ratios for Child Health, 1998. American Academy of Pediatrics, June, 2000. http://www.aap.org/research/complete.pdf Accessed February 20, 2002.

Crawford, L.; Marks, C.; Gawel, S.H.; White, E.; Obichere, L. 2000 Licensure and Examination Statistics. National Council of State Boards of Nursing Inc. http://www.ncsbn.org/public/regulation/re/2000lic_exam_statistics_report_on-line.pdf Accessed February 20, 2002.

Appendix 4.
Utilization and Insurance

Contents

Table 1: Percent of Children (under age 19) with a Preventive Dental Visit – Estimations for 2000-2001

All population numbers in thousands.

		With a Preventive Visit		With NO Preventive Visit	
	Total Number of Children < 19	Number	Percent of Total	Number	Percent of Total
Connecticut	922	433	47.0%	489	53.0%
Maine	320	145	45.5%	174	54.5%
Massachusetts	1,646	712	43.3%	933	56.7%
New Hampshire	**357**	**168**	**47.0%**	**189**	**53.0%**
Rhode Island	242	106	43.8%	136	56.2%
Vermont	174	78	44.6%	96	55.4%
New England	3,660	1,642	44.9%	2,018	55.1%
United States	76,476	31,351	41.0%	45,125	59.0%

Source: National Medical Expenditure Panel Survey Data, adjusted to the states' demography as reported on CPS for 2000-2001.

Table 2: Average Number of Dental Visits for Children (under age 19) – Estimations for 2000-2001

Populations and aggregate dental visits in thousands.

		Number Visiting a Dentist During the Year		Number of Dental Visits During the Year	
	Total Number of Children <19	Number	Percent with a Visit	Total Visits	Average Visits by by those with a Visit
Connecticut	922	468	50.8%	1,351	2.88
Maine	320	164	51.2%	460	2.81
Massachusetts	1,646	765	46.5%	2,155	2.82
New Hampshire	**357**	**184**	**51.4%**	**524**	**2.85**
Rhode Island	242	115	47.7%	333	2.89
Vermont	174	91	52.1%	259	2.86
New England	3,660	1,787	48.8%	5,083	2.84
United States	76,476	34,395	45.0%	93,191	2.71

Source: National Medical Expenditure Panel Survey Data, adjusted to the states' demography as reported on CPS for 2000-2001.

Table 3: Dental Insurance Coverage of Children (under age 19) by Source of Coverage Estimations for 2000-2001

All population numbers in thousands.

	Number of Children < 19			Number of Children by Type of Insurance Coverage				Percent of Total Children < 19			
				No Dental Coverage		With Dental Coverage		No Dental		With Dental	
	Total population	Number Without Dental Insurance	Percent of Total	No Health Insurance	Private Insurance	Private Insurance	Public Insurance	No Health Insurance	Private Insurance	Private Insurance	Public Insurance
Connecticut	922	304	33.0%	65	239	500	118	7.0%	26.0%	54.2%	12.8%
Maine	320	104	32.4%	25	79	139	77	7.9%	24.6%	43.6%	24.0%
Massachusetts	1,646	508	30.9%	156	352	661	477	9.5%	21.4%	40.1%	29.0%
New Hampshire	**357**	**115**	**32.1%**	**24**	**91**	**176**	**67**	**6.6%**	**25.5%**	**49.1%**	**18.8%**
Rhode Island	242	75	31.2%	14	62	122	45	5.7%	25.5%	50.4%	18.4%
Vermont	174	49	28.3%	16	33	56	69	9.1%	19.2%	32.1%	39.6%
New England	3,660	1,155	31.6%	299	856	1,653	852	8.2%	23.4%	45.2%	23.3%
United States	76,476	25,404	33.2%	10,499	14,905	33,734	17,338	13.7%	19.5%	44.1%	22.7%

Source: National Medical Expenditure Panel Survey Data, adjusted to the states' demography as reported on CPS for 2000-2001.

Table 4: Aggregate Annual Dental Expenditures for Children (under age 19) – Estimations for 2000-2001

All population numbers in thousands. Aggregate exependiture numbers in millions.

	Population		Aggregate Expenditures by Source				Distribution of Expenditures			Average Expenditure for Those with a Visit	
	Number Of Children	Number with a Visit	Total Expenditures	Insurance		Out-of-Pocket	Insurance		Out-of-Pocket	Total	Out-of-Pocket
				Private	Public		Private	Public			
Connecticut	922	468	$218	$100	$4	$114	46%	2%	52%	$466	$243
Maine	320	164	$56	$20	$4	$32	36%	7%	57%	$342	$194
Massachusetts	1,646	765	$325	$136	$19	$171	42%	6%	52%	$425	$223
New Hampshire	**357**	**184**	**$74**	**$31**	**$3**	**$40**	**42%**	**4%**	**54%**	**$403**	**$219**
Rhode Island	242	115	$53	$23	$2	$28	44%	3%	52%	$457	$239
Vermont	174	91	$28	$10	$3	$16	35%	11%	55%	$314	$172
New England	3,660	1,787	$755	$321	$35	$400	42%	5%	53%	$422	$224
United States	76,476	34,395	$15,157	$7,069	$736	$7,352	47%	5%	49%	$441	$214

Source: National Medical Expenditure Panel Survey Data, adjusted to the states' demography as reported on CPS for 2000-2001.

Table 5: Number and percent of children (under 19) at or below 200% of poverty – by health insurance coverage and state

All population numbers in thousands. SCHIP allocation formula.
Based on a November 2001 weighting correction.

		Total children at or below 200% of poverty					
				Insurance Coverage		No Insurance Coverage	
	Total children < 19	Total	Percent	Total	Percent	Total	Percent
Connecticut	905	181	20.0%	162	17.9%	19	2.1%
Maine	301	92	30.6%	75	25.0%	17	5.6%
Massachusetts	1,663	606	36.5%	537	32.3%	70	4.2%
New Hampshire	**335**	**79**	**23.6%**	**66**	**19.9%**	**13**	**3.7%**
Rhode Island	211	59	28.0%	54	25.6%	5	2.4%
Vermont	184	77	41.7%	65	35.6%	11	6.2%
United States	75,994	28,135	37.0%	22,574	29.7%	5,562	7.3%

Source: Current Population Survey. Annual Demographic Survey, March Supplement, Accessed February 8, 2002 at http://ferret.bls.census.gov/macro/032001/health/toc.htm

Appendix 5.
Medicaid and SCHIP

Prepared by David M. Krol, M.D.

Contents

ENROLLMENT & ELIGIBILITY

Table 1a: Number of Medicaid-eligible and CHIP-enrolled children

	Medicaid Eligible Children 2000	Rank Order	CHIP Enrollment 2000	Rank Order
Connecticut	217,468	2	10,572	3
Maine	78,283	3	60,854	1
Massachusetts	435,059	1	9,519	4
New Hampshire	**60,794**	**5**	**3,897**	**5**
Rhode Island	65,622	4	10,619	2
Vermont	60,629	6	2,485	6

Source: The Kaiser Commission on Medicaid and the Uninsured. CHIP program enrollment: December, 2000. http://www.kff.org/content/2001/4005/4005.pdf Accessed February 20, 2002.

Table 1b: Eligibility

	CHIP Federal Matching Rate FY2002[1]	Rank Order	Medicaid Federal Matching Rate FY2002[2]	Rank Order	CHIP upper income limit (%FPL) 2001[3]	Rank Order	CHIP Eligibility level (0-1) Dec. 2000[4]	Rank Order	CHIP Eligibility level (1-19) Dec. 2000[5]	Rank Order
Connecticut	65%	4	50%	4	300%	1	185%	5	185%	3
Maine	77%	1	50%	4	200%	3	250%	2	150%	4
Massachusetts	65%	4	67%	1	200%	3	225%	3	150%	4
New Hampshire	**65%**	**4**	**50%**	**4**	**300%**	**1**	**200%**	**4**	**185%**	**3**
Rhode Island	67%	3	52%	3	250%	2	300%	1	250%	1
Vermont	74%	2	63%	2	300%	1	200%	4	225%	2

Source: 1. Federal Register, November 17, 2000 (Vol. 65, No. 223), pp. 69560-69561.
2. Ibid.
3. Center for Medicare and Medicaid Services. The State Children's Health Insurance Program Annual Enrollment Report fiscal year 2001: October 1, 2000 - September 30, 2001. http://www.hcfa.gov/init/schip01.pdf Accessed February 20, 2002.
4. The Kaiser Commission on Medicaid and the Uninsured. CHIP program enrollment: December, 2000. http://www.kff.org/content/2001/4005/4005.pdf Accessed February 20, 2002.
5. Ibid.

DENTIST PARTICIPATION

Table 2: Dentist Participation

While these data suggest high levels of participation in Medicaid, the percentage accepting new patients and the percentage actively treating significant numbers of patients is considerably lower.

Dentist Participation

	Percent of dentists enrolled in CHIP 2001	Rank Order	Percent of dentists participating in the Medicaid dental program 2001	Rank Order
Connecticut	86%	1	88%	1
Maine	49%	4	20%	6
Massachusetts	NR	—	49%	3
New Hampshire	**76%**	**3**	**35%**	**5**
Rhode Island	NR	—	46%	4
Vermont	84%	2	84%	2

Source: Synopses of state dental public health programs, Center for Disease Control. http://www2.cdc.gov/nccdphp/doh/synopses/index.asp 2000 (unless otherwise noted) Accessed February 20, 2002.

Table 3: Dental Participation by Reimbursement

	Percentage of active dentists enrolled in Medicaid 1998	Rank Order	Percentage of active dentists receiving payment from Medicaid 1998	Rank Order	Percentage of active dentists receiving more than $10,000 from Medicaid 1998	Rank Order
Connecticut	32%	5	21%	5	4%	5
Maine	96%	1	25%	4	15%	3
Massachusetts	61%	4	56%	2	16%	2
New Hampshire	**81%**	**3**	**55%**	**3**	**15%**	**4**
Vermont	88%	2	88%	1	39%	1
Rhode Island	—	—	—	—	—	—

Source: Data collected by the National Conference of State Legislatures, Forum for State Health Policy Leadership; 1999. In States approaches to increasing Medicaid beneficiaries access to dental services, Epstein, CA November 2000.

Table 4: Medicaid Payment Rates as a Percentage of Average Regional Dental Fees for Selected Procedures, 1999

Region and state	Periodic oral examination	Dental cleaning child	Metal filling, 2 surfaces	Root canal, treatment	Extraction, single tooth	Of 15 Procedures number for which Medicaid exceeded 2/3 of average regional fees	Range of Medicaid rates as % of average regional fees
Connecticut	67%	52%	48%	46%	46%	1	45-67%
Maine	52%	72%	56%	49%	63%	2	50-75%
Massachusetts	36%	46%	47%	30%	52%	0	30-64%
New Hampshire	**73%**	**68%**	**61%**	**44%**	**46%**	**2**	**43-73%**
Rhode Island	40%	53%	43%	58%	45%	1	40-77%
Vermont	68%	63%	68%	65%	75%	5	53-85%

Source: General Accounting Office. Factors contributing to low use of dental services by low-income populations. GAO/HEHS-00-149. September, 2000.

EXPENDITURES

Table 5: Medicaid Total Expenditures

	MEDICAID Total Expenditures FY1998	Rank Order
Connecticut	$2,420,791,474	2
Maine	$747,027,618	4
Massachusetts	$4,609,360,933	1
New Hampshire	**$606,004,232**	**5**
Rhode Island	$919,353,410	3
Vermont	$351,341,290	6

Source: Health Care Financing Administration. HCFA-2082 Reports for Federal Fiscal year 1998, HCFA, CMSO, HCFA, 2082 REPORT, January 27, 2000. http://www.hcfa.gov/medicaid/msis/2082%D98.htm Accessed February 20, 2002.

Table 6: Medicaid Dental Expenditures

	MEDICAID Dental Expenditures FY1998	Rank Order
Connecticut	$7,461,733	4
Maine	$4,500,980	6
Massachusetts	$53,661,108	1
New Hampshire	**$4,589,120**	**5**
Rhode Island	$9,372,139	2
Vermont	$7,965,583	3

Source: Health Care Financing Administration. HCFA-2082 Reports for Federal Fiscal Year 1998, HCFA, CMSO, HCFA-2082 REPORT, January 27, 2000. http://www.hcfa.gov/medicaid/msis/2082%D98.htm Accessed February 20, 2002.

Table 7: New Hampshire Dental Medicaid Expenditures

Average Dental Payment per User and Percent of Enrollees Using Each Service

	New Hampshire				New England				United States			
	Children < 21		Adults		Children < 21		Adults		Children < 21		Adults	
	Per-user	% Use	Per-user	% Use	Per-user	% Use	Per-user	% Use	Per-user	% Use	Per-user	% Use
1995	$187	46.0%	$159	9.0%	$173	43.0%	$193	31.0%	$151	22.0%	$177	14.0%
1996	$195	44.7%	$153	8.5%	$159	37.7%	$184	28.8%	$161	21.0%	$186	12.8%
1997	$197	36.8%	$173	7.2%	$164	27.3%	$186	24.6%	$166	17.5%	$191	11.0%
1998	$185	37.3%	$246	12.7%	$170	23.1%	$209	17.6%	$172	13.7%	$204	7.7%

Source: AAP Medicaid State Reports based on State submissions of form 2082 to HCFA/CMS.

Table 8: Medicaid Utilization by Age 1998

	Rank Order	Medicaid recipients under age 1 year, FY 1998	Rank Order	Medicaid recipients ages 1-5 years, FY1998	Rank Order	Medicaid recipients ages 6-14 years, FY1998	Rank Order	Medicaid recipients ages 15-20 years, FY1998	Rank Order	Medicaid recipients over age 20 years FY 1998	Rank Order	Total Medicaid Recipients FY1998
Connecticut	2	11,337	2	61,527	2	91,304	2	38,712	2	178,328	2	381,208
Maine	4	4,257	4	22,420	3	36,703	3	18,827	3	86,525	3	170,456
Massachusetts	1	36,321	1	126,727	1	178,469	1	79,006	1	487,715	1	908,238
New Hampshire	**6**	**2,499**	**5**	**16,657**	**6**	**24,433**	**6**	**9,903**	**6**	**39,975**	**6**	**93,970**
Rhode Island	3	4,288	3	25,004	4	34,289	4	13,617	4	73,234	4	153,130
Vermont	5	2,410	6	15,757	5	26,550	5	12,569	5	65,047	5	123,992

Source: Health Care Financing Administration. HCFA-2082 Reports for Federal Fiscal Year 1998, HCFA, CMSO, HCFA, 2082 REPORT, January 27, 2000. http://www.hcfa.gov/medicaid/msis/2082%2D98.htm Accessed February 20, 2002.

Table 9: Actuarial Estimates of SCHIP Monthly Costs per Child Based on Market Rates

	Comprehensive Benefits Package Including Dental				Dental Benefits			
	Urban	Rank Order	Rural	Rank Order	Dental	Rank Order	% Dental	Rank Order
Connecticut	$119.36	1	$113.36	1	$25.62	1	21.5%	2
Maine	$105.96	5	$94.05	5	$19.80	5	18.7%	6
Massachusetts	$110.98	3	$94.02	6	$25.62	2	23.1%	1
New Hampshire	**$109.95**	**4**	**$99.76**	**3**	**$22.13**	**4**	**20.1%**	**4**
Rhode Island	$111.95	2	$105.93	2	$23.30	3	20.8%	3
Vermont	$102.27	6	$95.63	4	$19.80	6	19.4%	5
United States	$101.47	—	—	—	$21.35	—	21.0%	—

Source: American Academy of Pediatrics (paper): AAP summary of 1998 Total Projected Health Care Cost State & National Average Population: 0 - 21 Year Olds.

Appendix 6.
New Hampshire Demographics

Prepared by David M. Krol, M.D.

Contents

Table 1: Child Population by Race

	Black		White		Hispanic		Other		Total
Connecticut	93,061	11.3%	585,559	71.4%	115,659	14.1%	26,247	3.2%	820,526
Maine	2,450	0.8%	284,824	96.2%	3,590	1.2%	5,364	1.8%	296,228
Massachusetts	97,671	6.7%	1,128,792	77.4%	157,726	10.8%	75,053	5.1%	1,459,242
New Hampshire	**2,477**	**0.8%**	**289,164**	**94.9%**	**7,787**	**2.6%**	**5,288**	**1.7%**	**304,716**
Rhode Island	13,585	5.9%	180,075	78.4%	35,002	15.2%	1,011	0.4%	229,673
Vermont	1,020	0.7%	139,667	96.4%	1,836	1.3%	2,383	1.6%	144,906

Sources: QT-P1. Age groups and sex: 2000. Census 2000 Summary File 1 (SF1) 100 percent data. United States Census Bureau. http://factfinder.census.gov/servlet/QTTable? ts=32352659041 Accessed February 20, 2002.

2001 Kids Count Databook Online. Annie E. Casey Foundation, http://www.aecf.org/kidscount/kc2001/ Accessed February 20, 2002.

Table 2: Child Population by Age

	Under 5		5 to 9		10 to 14		15 to 18		Total
Connecticut	223,344	26.5%	244,144	29.0%	241,587	28.7%	132,613	15.8%	841,688
Maine	70,726	23.5%	83,022	27.6%	92,252	30.6%	55,238	18.3%	301,238
Massachusetts	397,268	26.5%	430,861	28.7%	431,247	28.7%	240,688	16.0%	1,500,064
New Hampshire	**75,685**	**24.4%**	**88,537**	**28.6%**	**93,255**	**30.1%**	**52,085**	**16.8%**	**309,562**
Rhode Island	63,896	25.8%	71,905	29.0%	71,370	28.8%	40,651	16.4%	247,822
Vermont	33,989	23.0%	41,101	27.9%	45,397	30.8%	27,036	18.3%	147,523

Sources: QT-P1. Age groups and sex: 2000. Census 2000 Summary File 1 (SF1) 100 percent data. United States Census Bureau. http://factfinder.census.gov/servlet/QTTable? ts=32352659041 Accessed February 20, 2002.

2001 Kids Count Databook Online. Annie E. Casey Foundation, http://www.aecf.org/kidscount/kc2001/ Accessed February 20, 2002.

Table 3: Percentage of Children in Poverty

	Poverty rate for children 18 and under 1999-2000 (%)	Rank Order
Connecticut	11	6
Maine	16	3
Massachusetts	23	1
New Hampshire	**12**	**5**
Rhode Island	16	4
Vermont	21	2
US	21	—

Sources: QT-P1. Age groups and sex: 2000. Census 2000 Summary File 1 (SF1) 100 percent data. United States Census Bureau. http://factfinder.census.gov/servlet/QTTable? ts=32352659041 Accessed February 20, 2002.

2001 Kids Count Databook Online. Annie E. Casey Foundation, http://www.aecf.org/kidscount/kc2001/ Accessed February 20, 2002.

Appendix 7.
Distribution of New Hampshire Oral Health Resources

Contents

Map 1: New Hampshire Health Service Areas

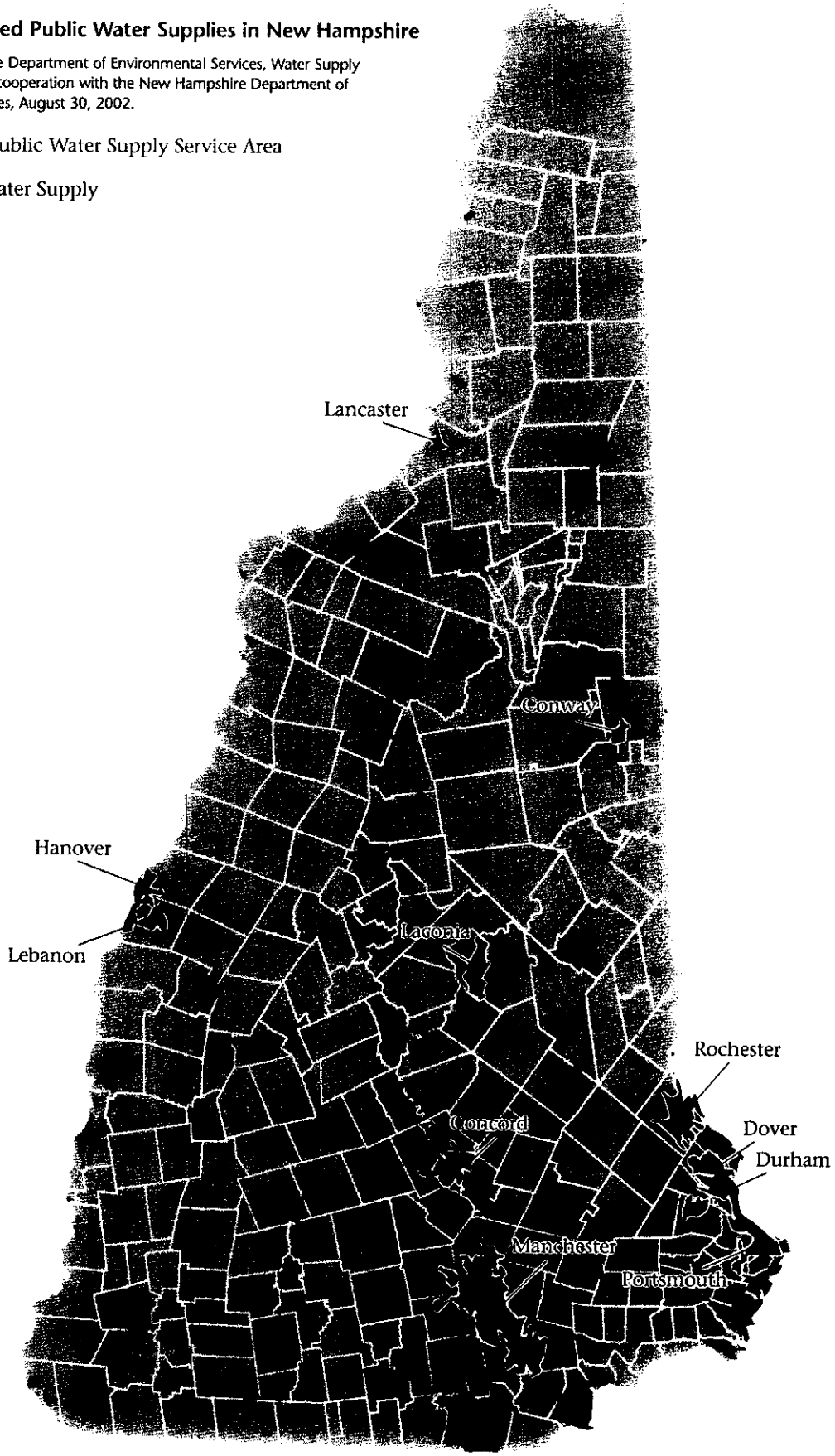
Source: New Hampshire Department of Health and Human Services, Office of Community and Public Health, Bureau of Health Statistics and Data Management, Janet Horne. August 30, 2002.

Map 2: Fluoridated Public Water Supplies in New Hampshire

Source: New Hampshire Department of Environmental Services, Water Supply Engineering Bureau, in cooperation with the New Hampshire Department of Health & Human Services, August 30, 2002.

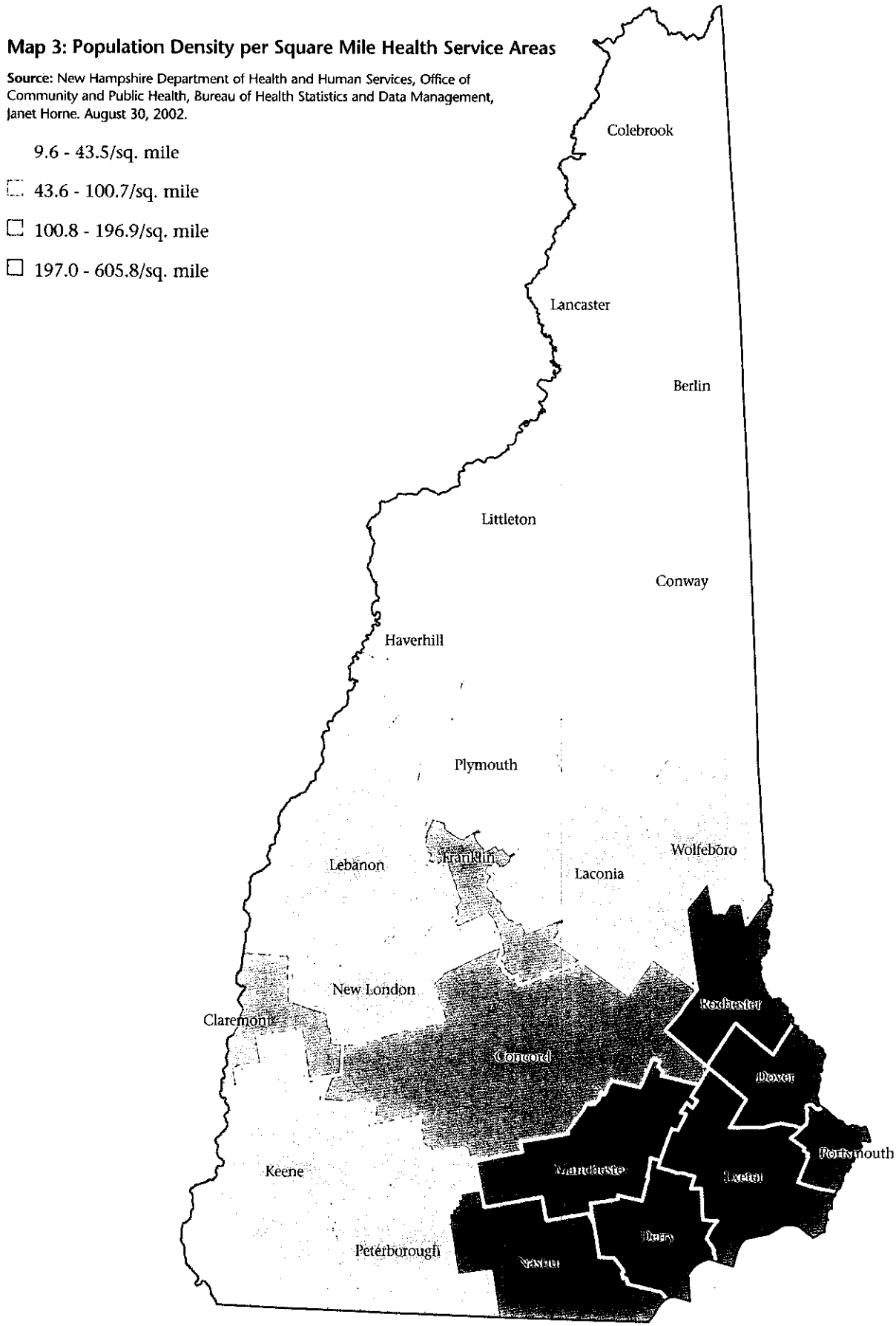
■ Community Public Water Supply Service Area

■ Fluroidated Water Supply



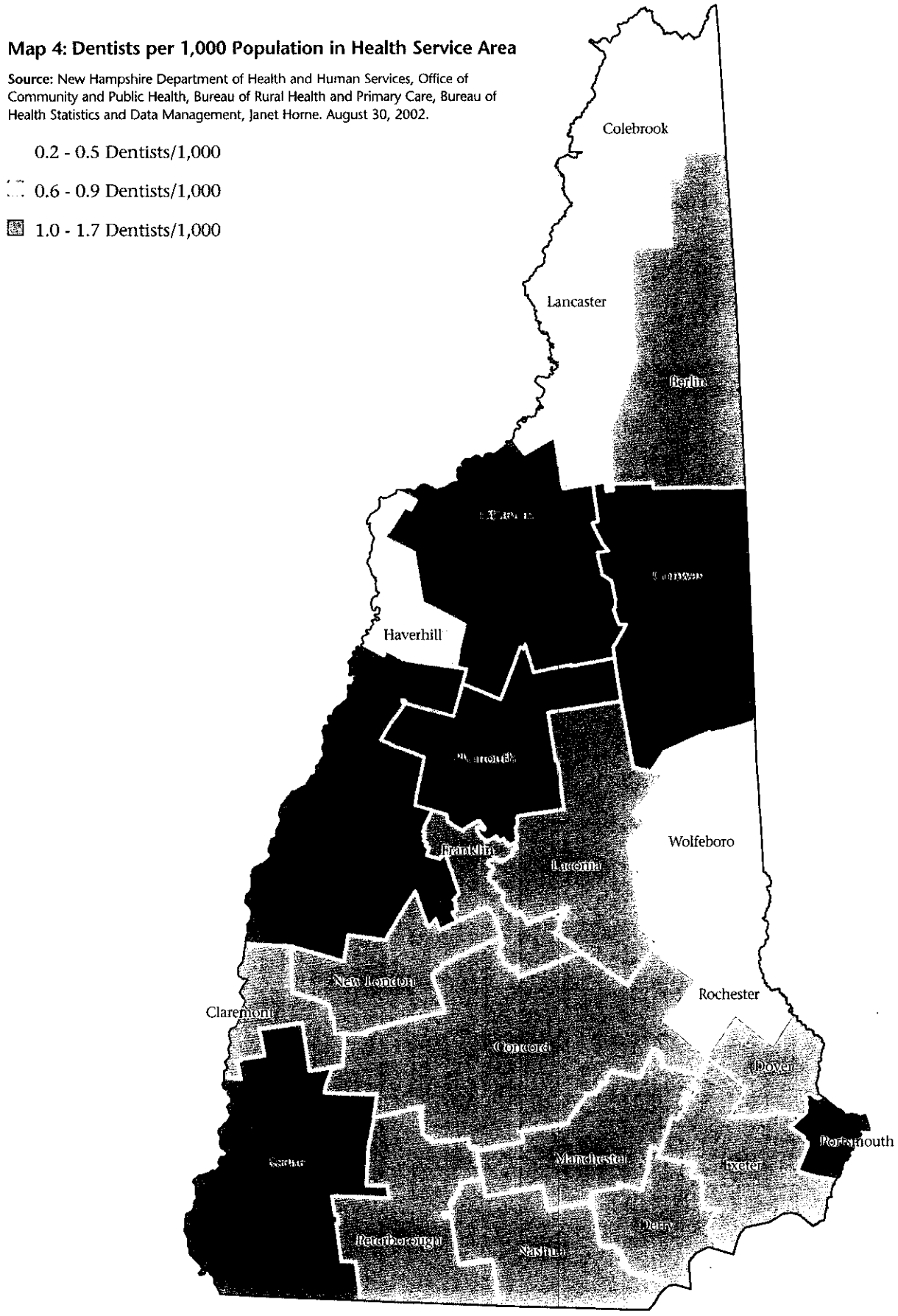
Map 3: Population Density per Square Mile Health Service Areas

Source: New Hampshire Department of Health and Human Services, Office of Community and Public Health, Bureau of Health Statistics and Data Management, Janet Horne. August 30, 2002.



Map 4: Dentists per 1,000 Population in Health Service Area

Source: New Hampshire Department of Health and Human Services, Office of Community and Public Health, Bureau of Rural Health and Primary Care, Bureau of Health Statistics and Data Management, Janet Horne. August 30, 2002.

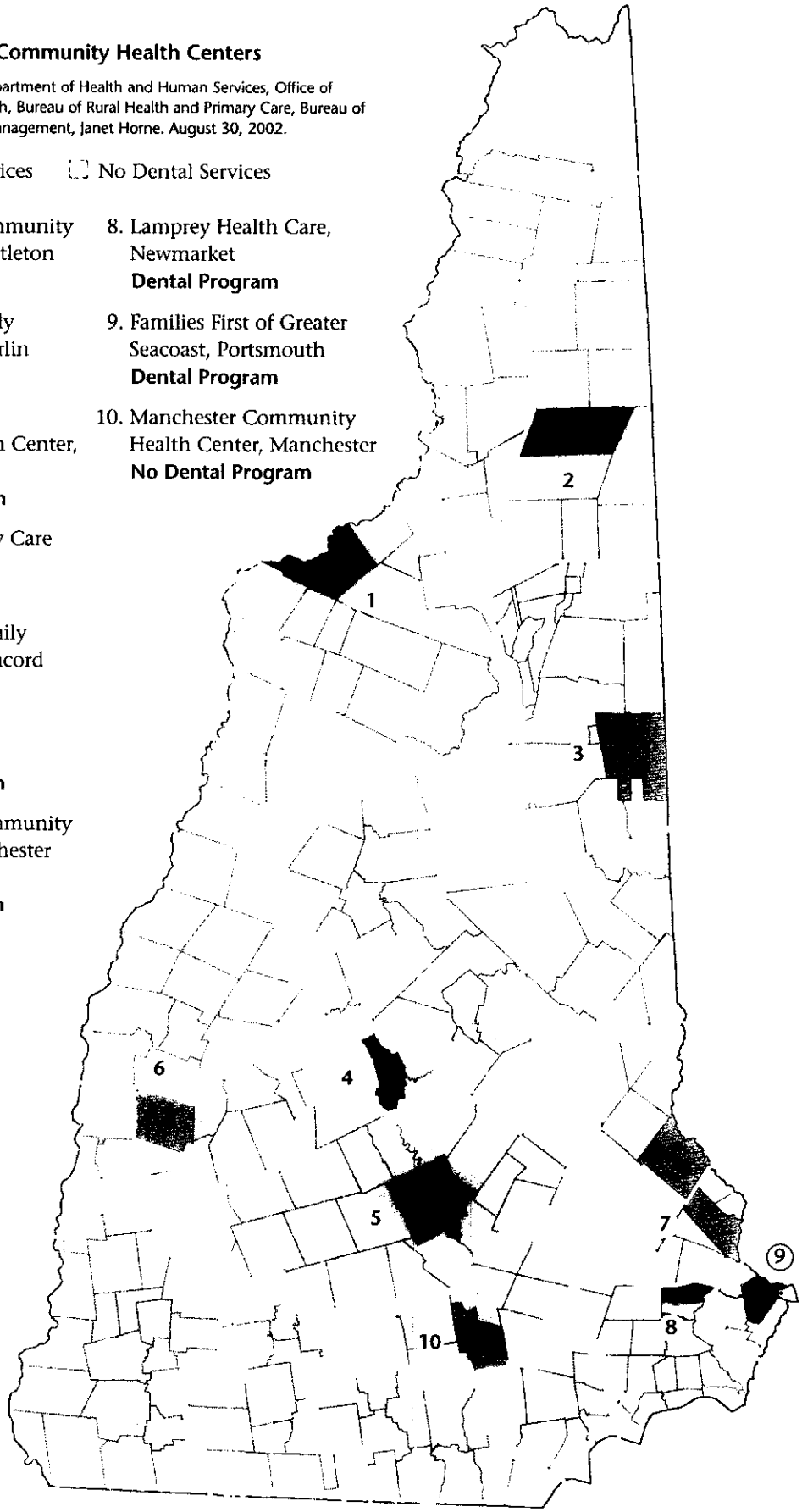


Map 5: Location of Community Health Centers

Source: New Hampshire Department of Health and Human Services, Office of Community and Public Health, Bureau of Rural Health and Primary Care, Bureau of Health Statistics and Data Management, Janet Horne. August 30, 2002.

■ Offers Dental Services ⬚ No Dental Services

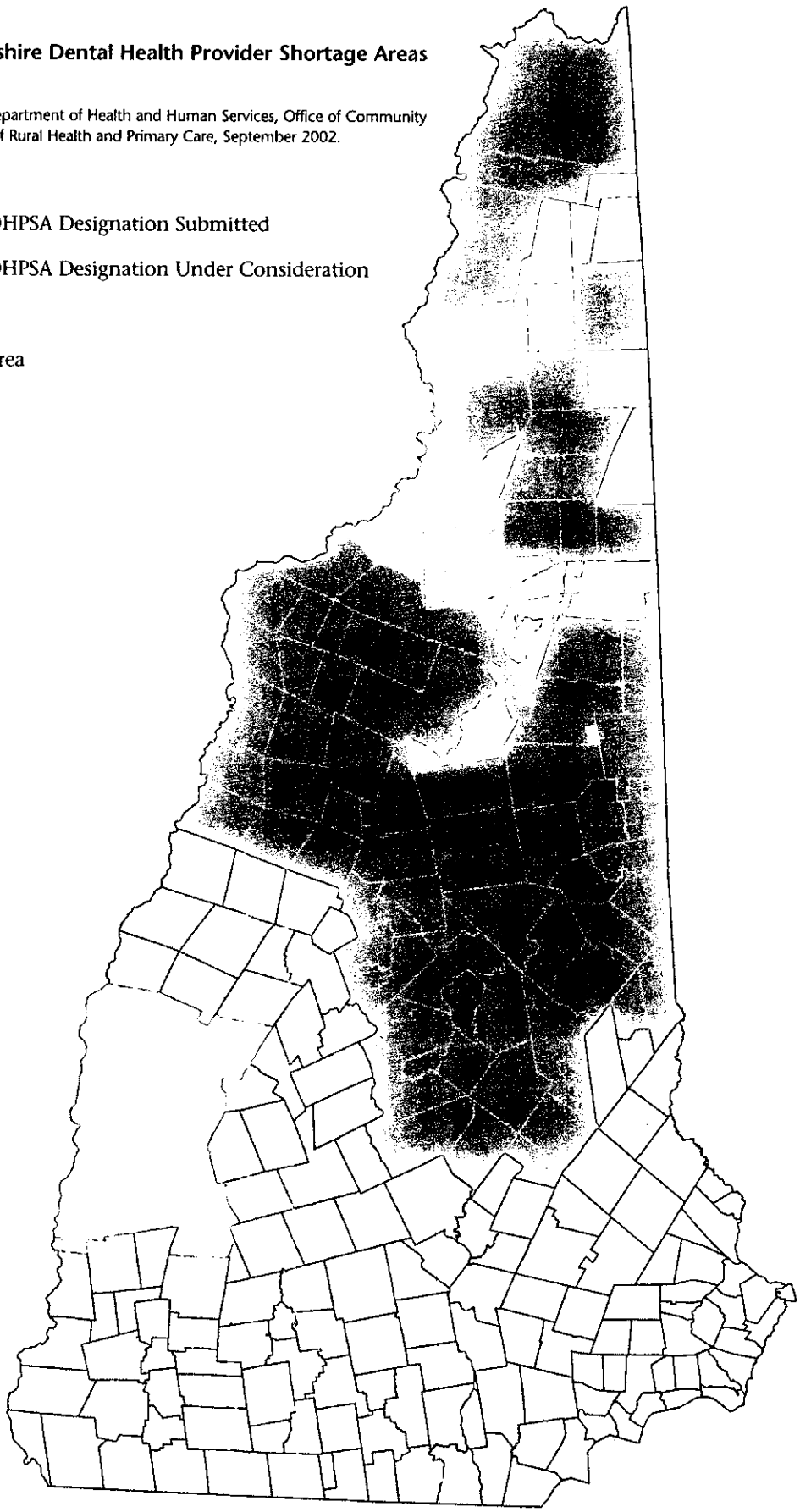
1. Ammonoosuc Community Health Services, Littleton
   Dental Program
2. Coos County Family Health Services, Berlin
   Dental Program
3. White Mountain Community Health Center, Conway
   No Dental Program
4. Health First: Family Care Center, Franklin
   Dental Program
5. Capital Region Family Health Center, Concord
   Dental Program
6. Partners in Health, Newport
   No Dental Program
7. Avis Goodwin Community Health Center. Rochester and Dover
   No Dental Program
8. Lamprey Health Care, Newmarket
   Dental Program
9. Families First of Greater Seacoast, Portsmouth
   Dental Program
10. Manchester Community Health Center, Manchester
    No Dental Program



Map 6: New Hampshire Dental Health Provider Shortage Areas (DHPSA)

Source: New Hampshire Department of Health and Human Services, Office of Community and Public Health, Bureau of Rural Health and Primary Care, September 2002.

- ☐ DHPSA
- ☐ Application for DHPSA Designation Submitted
- Application for DHPSA Designation Under Consideration
- Unpopulated
- ☐ Not a Shortage Area



If you would like to receive additional copies of the *New Hampshire Oral Health Plan: A Framework for Action*, and learn more about the Coalition for New Hampshire Oral Health Action contact:

Coalition for New Hampshire Oral Health Action
c/o The Endowment for Health
14 South Street • Concord, NH 03301
Phone: 603-228-2448 • E-Mail: info@endowmentforhealth.org

This report is also available online at: www.endowmentforhealth.org and www.dhhs.state.nh.us/DHHS/ORALHEALTH/default.htm

ATTACHMENT #9

NEW HAMPSHIRE VOICES FOR HEALTH

American Cancer Society • American Heart Association • Early Learning, NH
Georgetown University Center for Children & Families • Granite State Organizing Project
National Alliance on Mental Illness, NH • New Hampshire AFL-CIO EAP Services
New Futures • New Hampshire for Health Care • New Hampshire Minority Health Coalition
New Hampshire Women's Lobby & Alliance • North Country Health Consortium

Senate Health and Human Services Committee
April 6, 2010
New Hampshire Voices for Health Testimony

RE: HB 1537, An Act allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program

Madam Chair and members of the committee, thank you for this opportunity to provide testimony in support of HB 1537. NH Voices for Health is a network of consumer and advocacy organizations, small businesses and individuals allied in their commitment to securing quality, affordable health care for all in New Hampshire. The network represents over 200,000 members, consumers and constituents statewide.

NH Voices for Health strongly supports HB 1537, a bipartisan bill that would provide reimbursement to primary care providers who deliver preventative oral health services to children up to age 3 enrolled in the state Medicaid program.

Good oral health is essential to good overall health. Dental disease can lead to a number of other diseases, including heart disease, diabetes and stroke. While dental disease is preventable, a lack of access to oral health care among children in Medicaid, in part due to a shortage of pediatric dentists, is contributing to high rates of tooth decay and, in turn, other health problems.

Reimbursing primary care providers for dental screenings and applying fluoride varnish, as HB 1537 seeks to establish, is becoming a best practice for ensuring access to preventive oral health care and saving states money by promoting preventive health care. Thirty-five other states across the country, including all New England states except New Hampshire, recognize the importance of ensuring that children have access to preventive oral health care and offer Medicaid reimbursement to primary-care medical providers who perform oral health screenings and/or preventive services.

By providing such reimbursement through NH Healthy Kids Gold, New Hampshire could ensure that children have access to the oral health care they need to stay healthy and prevent more intensive and expensive health care needs. Providing this reimbursement would allow New Hampshire's youngest children to get preventive oral health care services at a provider they are already going for regular preventive services and would promote integration of health care, ensuring that New Hampshire children have well-coordinated access to the full continuum of needed health care.

Importantly, this bill proposes proposed expanding access to preventive oral health care services simply by expanding the providers who can reimbursed for those services and does not propose expanding the number of eligible recipients or providing new services. In addition, HB 1537 will have no fiscal impact on the state this biennium.

We urge the committee to support HB 1537 with an "ought to pass" recommendation.

Thank you for your attention and consideration. We are happy to be a resource to you as you consider this and other legislation that affects access to quality, affordable health care and coverage. Please do not hesitate to call on us by contacting Lisa Kaplan Howe, Director of New Hampshire Voices for Health at 369-4767 or lisa@nhvoicesforhealth.org.

Wolfeboro Pediatrics

A Department of Huggins Hospital

Medical Arts Center, Suite C, 240 South Main Street
PO Box 599, Wolfeboro, NH 03894-0599
603.569.7620 fax 603.569.7619
www.hugginshospital.org

Harley W. Heath, MD
Michael E. Matos, MD
Deborah A. Stone, PNP

ATTACHMENT # 10

Pediatric Oral Health Initiative in NH

Michael Matos, MD/FAAP

Michael E Matos MD

- Compared to more affluent peers, preschoolers in poverty....
  - have twice the incidence of tooth decay
  - experience dental pain twice as often
- Poor dental health persists - in the Gov. Wentworth Regional School District, dental disease is the 2nd most common cause of school absenteeism

- Pediatricians do not want to be dentists, but dental health is part of overall health

- The Amer. Dental Assoc. & Amer. Acad. of Pediatric Dentistry recommend a first dental visit at *no later than 1 yo*
  - Of the ~7 dentists in the Wolfeboro area, only 2 see children under 2 yo
  - Closest pediatric dentist offices to southern Carroll County are in
    - Rochester (practice closed to new Medicaid patients) &
    - Concord (primarily used as referral center by local families)
  - Pediatricians see children at 0, 1, 2, 4, 6, & 9 months for well care
  - The pediatrician / parent / patient relationship is well established by 1 yo

- THE BOTTOM LINE - how are dollars for dental care best spent?
- Prevention is the key - the story of Patient DC
  - Followed from birth at Wolfeboro Pediatrics
  - Guardians reported inability to find a dentist willing to see DC
  - At age 5, DC developed severe dental caries, abscess, and pain
  - Dental pain affected speech, sleep, & behavior
  - Hospitalization alone (i.e., not including provider charges) cost $17,000
  - If pediatricians could be reimbursed $50 per treatment, then *340* dental assessments & treatments could have been done for that cost

ATTACHMENT #11

New Hampshire HEALTHY KIDS

1 Pillsbury Street, Suite 300, Concord, NH 03301-3556
Tel: 603-228-2925 • Fax: 603-228-8940
www.nhhealthykids.com

NH Healthy Kids Corporation
1 Pillsbury Street, Suite 300
Concord, NH 03301
(603) 228-2925

Written Testimony of NH Healthy Kids Corporation
Gail M. Garceau, President and CEO
IN SUPPORT OF House Bill 1537
Before the Senate Health and Human Services Committee
April 6, 2010

NH Healthy Kids Corporation (NHHK) supports the concept of House Bill 1537 to permit primary care providers to deliver preventive oral health services to children in accordance with our philosophy to promote healthy lifestyles, encourage preventive health and dental care, treat illness early and manage chronic health conditions. On behalf of the New Hampshire Healthy Kids Silver population, New Hampshire Healthy Kids would like to request that those covered under our Silver program be included in any action on this Bill that would assist in expanding access to necessary dental services. Our partner, Northeast Delta Dental, has already considered this initiative, and we believe these services can be provided to the New Hampshire Healthy Kids Silver population at no additional costs, presuming we receive federal approval.

Under a contractual partnership with the New Hampshire Department of Health & Human Services, NHHK leads the effort to educate the public about children's health coverage options and to assist families in applying for coverage. NHHK directly administers the premium-based SCHIP/Title XXI program through insurance subcontracts with Harvard Pilgrim Health Care and Northeast Delta Dental, covering approximately 8,047 of New Hampshire's children. In addition, our headquarters in Concord serves as the mail-in application and enrollment center for both Medicaid and SCHIP, known as Healthy Kids Gold and Silver respectively.

NH Healthy Kids' vision is for every child to go to school healthy and ready to learn. We support broader oral health care access for Medicaid and SCHIP enrollees and value early intervention and preventive care. It has been proven that oral health is integral to the overall health and well-being of children. In a 2000 report, "the U.S. Surgeon General stated that oral health is a key determining factor in the condition of a child's overall health".[1]

According to the Healthy Smiles Healthy Children Foundation of the American Academy of Pediatric Dentistry 2009 Annual Report,

- *Over 40%-50% of children will be affected by tooth decay by the age of 5*
- *Of the 4 million children born each year, more than half will have cavities by the time they reach second grade*

[1] National Academy for State Health Policy, *Briefing: Engaging Primary Care Medical Providers in Children's Oral Health*, Chris Cantrell, September 2009

- *According to the May 2000 Surgeon General's report, Oral Health in America, more than 51 million school hours are lost each year to dental-related conditions*[2]

New Hampshire has consistently proved to be a pioneer in covering kids and providing outstanding medical and dental coverage in Medicaid and SCHIP. With regard to permitting primary care providers to deliver preventive oral health services to children, New Hampshire has fallen behind. Two-thirds of the nation's Medicaid programs have already implemented these screenings with proven success. New Hampshire is the only state in New England not providing this service.

There are thousands of children in New Hampshire without health and dental insurance. While NH Healthy Kids works to reach those children, it is imperative that we ensure that the 75,415 enrolled in Healthy Kids Gold and 8,047 enrolled in Healthy Kids Silver receive quality preventive medical and dental care. HB 1537 is a step in the right direction to expand the access New Hampshire's most vulnerable population has to receiving timely and effective oral health services.

NH Healthy Kids supports the concept of House Bill 1537 and seeks to have Healthy Kids Silver members included in a State Plan Amendment where appropriate. Thank you in advance for your consideration.

[2] Healthy Smiles Healthy Children; The Foundation of the American Academy of Pediatric Dentistry. (2010). *2009 Annual Report.* Retrieved from http://www.aapd.org/foundation/pdfs/2009/HSHC2009AnnualReport.pdf

ATTACHMENT #12

April 6, 2010

Dear Members of the Senate Health and Human Services Committee:

In reference to HB1537: Relative to an act allowing primary care providers to provide preventive oral health services to children under the state Medicaid program.

As Director of the Council for Children and Adolescents with Chronic Health Conditions I am here to support the passing of HB 1537. New Hampshire has a growing population of children who contend with chronic health conditions and tooth decay is the single most common chronic disease among these children. Children who contend with other chronic health conditions may be at higher risk of tooth infections due to a suppressed immune system.

Also, it's estimated that nearly 20 percent of children ages 24 to 60 months contend with early childhood caries (ECC), a destructive tooth decay process that frequently requires expensive and extensive intervention, and can be transmitted from adult to child. ECC can substantially affect the overall health and well being of a child. ECC can cause severe pain, swelling, and compromise a child's ability to thrive. Delayed recognition and treatment of can result in costly restorative treatment, and can affect a person's lifelong ability to speak, thrive, learn, and work.

The American Academy of Pediatrics' Bright Futures guidelines recommend that children see a physician 11 times by age the age of two. The timing and frequency of these checkups provide a perfect opportunity to assess the health of a child's mouth, as well as provide preventive dental services. For parents who have a child with a chronic health condition the balance between visits with specialists, hospitalizations, typical well child visits and dental visits can be extremely overwhelming. Many times dental issues can be overlooked when parents are faced with a diagnosis of conditions like cancer, diabetes and cardiac conditions yet the onset of dental disease to these children can be life threatening.

Therefore, the Council for Children and Adolescents supports HB1537.

Sincerely,

Denise A. Brewitt

Denise A. Brewitt
Executive Director, CCACHC
(603) 271-7045
www.ccachc.org
dbrewitt@ccachc.org

Speakers

SENATE HEALTH AND HUMAN SERVICES COMMITTEE

Date: 4-06-10 **Time:** 8:45 AM **Public Hearing on** HB 1537

HB 1537 - (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

Please check box(es) that apply:

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING/TELEPHONE
☑	☒	☐	REP. JOHN CEBROWSKI	472 9113
☑	☒	☐	Rep PETER BATULA	
☒	☒	☐	Rep Rick Di PENTIMA	559-9765
☒	☒	☐	Tim Soucy	Manchester Health Dept 624-6466
☒	☒	☐	Suzanne Boulter, MD	496-5111
☑	☒	☐	Catrina Watson NHHS	224-1909
☑	☑	☐	Angela Boyle	NH Oral Health Coalition
☑	☑	☐	Marie Mulroy (MARIE MULROY)	Breathe NH 669-2411
☑	☐	☐	Gail Garceau	NH Healthy Kids 415-1800
☑	☑	☐	Kathy Mandeville (MANDEVILLE) RN, MS, MPA	NH resident of 36 years & 472-5444
☑	☒	☐	James J. Williamson	- N.H. Dental Society
☑	☒	☐	Lisa Kaplan Howe	- NH Voices for Health
☑	☒	☐	Hope Saltmarsh RDH, MEd	224-1468
☑	☒	☐	Rep Frank Kotowski (KOTOWSKI)	HHSEA 485-9579
☒	☐	☐	Lisabritt Solsky	DHHS 2718192
☒	☐	☐	Rep Carla Skinder (CARLA SKINDER)	Sullivan 1 542-6065
☐	☒	☐	Kristina Diamond	NHPHA 715-1389
☐	☒	☐	Senator Peggy Gilmour	271-3569
☐	☐	☐		

SENATE HEALTH AND HUMAN SERVICES COMMITTEE

Date: 4-06-10 **Time:** 8:45 AM **Public Hearing on** HB 1537

HB 1537 - (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

Please check box(es) that apply:

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING/TELEPHONE
☐	☑	☐	Alida Millham	Belknap #5
☑	☑	☐	Denise Brewitt	Council for Children & Adolescents with Chronic Health Conditions
☐	☐	☐		
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SENATE HEALTH AND HUMAN SERVICES COMMITTEE

Date: 4-06-10 **Time:** 8:45 AM **Public Hearing on** HB 1537

HB 1537 - (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

Please check box(es) that apply:

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING/TELEPHONE
☐	☑	☐	Susan Paschell	NH Dental Hygienists Ass'n.
☐	☑	☐	Rep. Mary Lucas Gile	Merr. 10 co-sponsor-orig.
☐	☑	☐	Rep Jerry Emerton	Hills- 7
☐	☐	☐		
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Testimony

Breathe
NEW HAMPSHIRE

A

April 6, 2010

Testimony
Breathe New Hampshire
HB 1537 –AN ACT allowing primary care providers to provide preventive oral health services to children under the state Medicaid program

I want to thank you for allowing Breathe New Hampshire to provide testimony in support of HB 1537, a bill which would train and allow primary care providers to perform much needed dental screenings and fluoride treatments for children on Medicaid. Throughout recent years the research increasingly shows that good chronic disease management must include good oral health care. This is especially true for children with asthma and other chronic disease conditions.

Breathe New Hampshire is a local organization and our mission is to ensure that everyone in New Hampshire takes the healthiest breath possible through prevention and good management of lung disease. At Breathe New Hampshire one of our core functions is to work with parents and teachers to educate them on how to best care for children with asthma. Part of that care includes the ability to effectively manage asthma by including good preventive dental care. The types of oral medicines that are prescribed for asthma may put children at risk for dental problems because these children can have drier mouths. Dry mouths can increase the risk of dental cavities because of decreased production of protective saliva in the mouth.

According to a study by C.F. Salinas, Opala and Hardin of the Medical University of South Carolina entitled "Caries Experience in Children with Asthma" they note that children with asthma have significantly higher rates for decayed, missing and filled teeth for both their primary and permanent teeth. The significant number of children with asthma who are on Medicaid and are taking asthma medications points to the need for more aggressive dental prevention protocols as soon as a diagnosis of asthma is made. Allowing these childrens' primary care provider to perform fluoride treatments will protect this vulnerable population and is a vital component to good disease management. It also provides the most expedient time between a diagnosis of asthma and the ability to protect children's teeth prior to the administration of oral inhaled medications.

Thank you for allowing Breathe New Hampshire to provide support for this bill. If you need further information regarding the health concerns surrounding idling feel free to contact Marie Mulroy (mmulroy@breathenh.org) at 669-2411.

B

New Hampshire Public Health ASSOCIATION

April 6, 2010

Subject: HB 1537 – An act allowing primary care providers to provide preventive oral health services to children under the state Medicaid program

Dear Chairman Sgambati and Members of the Senate Health and Human Services Committee:

The New Hampshire Public Health Association asks that you **support** HB 1537 which allows primary care providers to provide preventive oral health services to children under the state Medicaid program.

Good oral health is an essential part of overall health. Dental disease is associated with heart disease, stroke and diabetes.[1] Tooth decay in children can cause pain, absence from school, difficulty concentrating on learning, and poor appearance. Low income children are more likely to suffer from these problems.[2] The New Hampshire Department of Health and Human Services just released their *Third Grade Healthy Smiles –Healthy Growth Survey*. The results showed that 43.6% of New Hampshire's third graders experienced tooth decay and 12% of them had untreated tooth decay. In addition, students participating in the free and reduced lunch program experienced more tooth decay and were less likely to have dental sealants.[3]

Dental disease is preventable. The New Hampshire Public Health Association (NHPHA) supports access to preventative and therapeutic oral care for all. While there have been recent efforts to improve access to professional oral care for New Hampshire's indigent, access remains a major problem for many of the State's high risk populations such as children and the elderly. NHPHA supports initiatives for increased access to evidenced based screening and preventative care for oral health, including fluoridation and application of dental sealants.

The proposed legislation before us today will help provide low income children with better access to preventive oral health services. Individuals are more likely to see a physician rather than a dentist, and this is especially true for very young children. Trained primary care providers will not only be able to deliver services such as dental screenings and fluoride varnish treatments, they can also help assist their patients in finding a dental home. This is important because physicians can provide preventive oral health services to those that are most at risk for dental disease.

P.O. Box 2304, Concord, NH 03302-2304
Telephone: (603) 228-2983 Website: www.nhpha.org

[1] Centers for Disease Control and Prevention: "Preventing Cavities, Gum Disease, and Tooth Loss: At a Glance 2009.
[2] Centers for Disease Control and Prevention: "Preventing Cavities, Gum Disease, and Tooth Loss: At a Glance 2009.
[3] New Hampshire Department of Health and Human Services: "New Hampshire 2008-09 Third Grade *Healthy Smiles – Healthy Growth Survey*".

Medicaid-enrolled children are more than twice as likely as privately insured children to access an ED for a dental emergency suggesting that barriers to general dental care may exist for these children.[4] Furthermore, recent data submitted by NH Medicaid Office of Business and Policy indicates in 2007 there were 436 children seen in NH hospital operating rooms and another 547 children in 2008.[5] NHPHA strongly supports this bill because it will help keep health care costs down and provide access to preventive oral health services to the New Hampshire children that most need it.

The New Hampshire Public Health Association bases its opinions and recommendations on scientific evidence and fact-based strategies that promote health and reduce disease and injury. The Association has more than 200 members of individuals and organizations committed to the public health and safety of all New Hampshire residents.

I am happy to address any questions you might have regarding my testimony. Please feel free to contact me at anytime at (603) 545-1389. Thank you for your attention.

Sincerely,

Kristina L. Diamond

Kristina L. Diamond
Executive Director
New Hampshire Public Health Association

[4] New Hampshire Center for Public Policy Studies: Dental Services and Workforce in New Hampshire, January 2010

[5] Commission to study preventing dental disease among new Hampshire's children: Final Report on HB 414, November 2009.

Voting Sheets

Senate Health and Human Services Committee

EXECUTIVE SESSION

Bill # HB 1537

Hearing date: April 6, 2010

Executive session date: April 13, 2010

Motion of: OTP VOTE: 5-0

Made by Senator:	Sgambati	☐	**Seconded by Senator:**	Sgambati	☐	**Reported by Senator:**	Sgambati	☐
	Gilmour	☐		Gilmour	☑		Gilmour	☑
	Kelly	☑		Kelly	☐		Kelly	☐
	Gallus	☐		Gallus	☐		Gallus	☐
	Downing	☐		Downing	☐		Downing	☐

Motion of: _____ VOTE: _____

Made by Senator:	Sgambati	☐	**Seconded by Senator:**	Sgambati	☐	**Reported by Senator:**	Sgambati	☐
	Gilmour	☐		Gilmour	☐		Gilmour	☐
	Kelly	☐		Kelly	☐		Kelly	☐
	Gallus	☐		Gallus	☐		Gallus	☐
	Downing	☐		Downing	☐		Downing	☐

Committee Member	*Present*	Yes	No	*Reported out by*
Senator Sgambati, Chairman	☑	☑	☐	☐
Senator Gilmour, Vice-Chair	☑	☑	☐	☑
Senator Kelly	☑	☑	☐	☐
Senator Gallus	☑	☑	☐	☐
Senator Downing	☑	☑	☐	☐

*Amendments: _____

Notes: _____

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: April 13, 2010

THE COMMITTEE ON Health and Human Services

to which was referred House Bill 1537

AN ACT (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

Having considered the same, the committee recommends that the Bill:

OUGHT TO PASS

BY A VOTE OF: 5-0

AMENDMENT # s

Senator Peggy Gilmour
For the Committee

Deb Chroniak 271-3096

New Hampshire General Court - Bill Status System

Docket of HB1537

Docket Abbreviations

Bill Title: (New Title) allowing primary care providers to provide preventive oral health services to children between 0 and 3 years of age under the state Medicaid program.

Official Docket of **HB1537**:

Date	Body	Description
01/06/2010	H	Introduced and Referred to Health, Human Services and Elderly Affairs; **HJ 6**, PG.243
01/06/2010	H	Public Hearing: 1/12/2010 11:00 AM LOB 205
01/12/2010	H	Subcommittee Work Session: 1/19/2010 8:30 AM LOB 205
01/13/2010	H	==CANCELLED== Executive Session: 1/20/2010 9:30 AM LOB 205
01/19/2010	H	Subcommittee Work Session: 1/26/2010 12:45 PM LOB 205
01/20/2010	H	==CANCELLED== Executive Session: 1/26/2010 1:00 PM LOB 205
01/27/2010	H	Executive Session: 2/2/2010 10:00 PM LOB 205
02/02/2010	H	Committee Report: Ought to Pass with AM #0232h (NT) for Feb 10 CC (vote 18-0); **HC 13**, PG.528-529
02/02/2010	H	Proposed Committee Amendment #0232h (New Title); **HC 13**, PG.572-573
02/10/2010	H	Removed from Consent Calendar (Rep Vaillancourt); **HJ 16**, PG.748
02/10/2010	H	Amendment #0232h (New Title) Adopted, VV; **HJ 16**, PG.779
02/10/2010	H	Ought to Pass with Amendment #0232h (New Title): MA VV; **HJ 16**, PG.779
02/10/2010	H	Referred to Finance; **HJ 16**, PG.779
02/11/2010	H	Full Committee Work Session: 2/16/2010 10:01 AM LOB 210-211
02/11/2010	H	Executive Session: 2/18/2010 11:00 AM LOB 210-211
02/23/2010	H	Majority Committee Report: Ought to Pass for Mar 24 (Vote 14-8; RC); **HC 22**, PG.1223
02/23/2010	H	Minority Committee Report: Refer to Interim Study; **HC 22**, PG.1223
03/24/2010	H	Ought to Pass: MA DIV 206-140; **HJ 30**, PG.1501
03/24/2010	S	Introduced and Referred to Health and Human Services; **SJ 11**, Pg.264
03/31/2010	S	Hearing: April 6, 2010, Room 103, State House, 8:45 a.m.; **SC14**
04/13/2010	S	Committee Report: Ought to Pass 4/21/10; **SC16**
04/21/2010	S	Ought to Pass, MA, VV; OT3rdg; **SJ 15**, Pg.318
04/21/2010	S	Passed by Third Reading Resolution; **SJ 15**, Pg.325
05/05/2010	S	Enrolled
05/05/2010	H	Enrolled; **HJ 38**, PG.1914
05/24/2010	H	Signed by the Governor 05/19/2010; Effective 07/18/2010; Chapter 0076

Other Referrals

COMMITTEE REPORT FILE INVENTORY

HB 1537-FN ORIGINAL REFERRAL _____ RE-REFERRAL

1. THIS INVENTORY IS TO BE SIGNED AND DATED BY THE COMMITTEE SECRETARY AND PLACED INSIDE THE FOLDER AS THE FIRST ITEM IN THE COMMITTEE FILE.
2. PLACE ALL DOCUMENTS IN THE FOLDER FOLLOWING THE INVENTORY IN THE ORDER LISTED.
3. THE DOCUMENTS WHICH HAVE AN "X" BESIDE THEM ARE CONFIRMED AS BEING IN THE FOLDER.
4. THE COMPLETED FILE IS THEN DELIVERED TO THE CALENDAR CLERK.

✓ **DOCKET (Submit only the latest docket found in Bill Status)**

✓ **COMMITTEE REPORT**

✓ **CALENDAR NOTICE on which you have taken attendance**

✓ **HEARING REPORT (written summary of hearing testimony)**

✓ **HEARING TRANSCRIPT (verbatim transcript of hearing)**
List attachments (testimony and submissions which are part of the transcript) by number [1 thru 4 or 1, 2, 3, 4] here: _____

✓ **SIGN-UP SHEET**

ALL AMENDMENTS (passed or not) CONSIDERED BY COMMITTEE:

____ - AMENDMENT # _____ ____ - AMENDMENT # _____
____ - AMENDMENT # _____ ____ - AMENDMENT # _____

ALL AVAILABLE VERSIONS OF THE BILL:

✓ AS INTRODUCED ✓ AS AMENDED BY THE HOUSE
✓ FINAL VERSION ____ AS AMENDED BY THE SENATE

✓ **PREPARED TESTIMONY AND OTHER SUBMISSIONS (Which are not part of the transcript)**
List by letter [a thru g or a, b, c, d] here: A AND (B)

✓ **EXECUTIVE SESSION REPORT**

____ **OTHER (Anything else deemed important but not listed above, such as amended fiscal notes):**

IF YOU HAVE A RE-REFERRED BILL, YOU ARE GOING TO MAKE UP A DUPLICATE FILE FOLDER

DATE DELIVERED TO SENATE CLERK 8-5-10 _____
COMMITTEE SECRETARY